Supreme Court, U.S.
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No. 85-1385 (6)

In the Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI FILED FEBRUARY 18, 1986
CERTIORARI GRANTED JUNE 16, 1986

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UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

No. 85-760

GENERAL DYNAMICS CORP., ET AL., PLAINTIFFS-APPELLEES

v.

UNITED STATES OF AMERICA, DEFENDANT-APPELLANT

RELEVANT DOCKET ENTRIES

November 23, 1984	1.	Certificate of Interest filed by Plaintiff-Appellee. (ak)
January 11, 1985	2.	Appellant's motion for an extension of time (to and including February 11, 1985) to file its opening brief and appendix, filed. (SD-1/10-M) (ejc) GRANTED: January 17, 1985. (ejc)
January 17, 1985	3.	Appellee's response to appellant's motion for an extension of time to file its brief, filed. (SD-1/14-M) (ejc) (SHOULD CIRCUMSTANCES REQUIRE AN EXTENSION OF TIME FOR APPELLEES TO FILE THEIR BRIEF, A MOTION TO THAT EFFECT WILL HAVE TO BE MADE AT THE APPROPRIATE TIME.) (ejc)

February 7, 1985	4.	Appellant's motion for an extension of time (to and including February 18, 1985) to file its brief and appendix, filed. (SD-2/7-M) (ejc) GRANTED: February 8, 1985. (ejc)
February 19, 1985		BRIEF/SEPARATE APPENDIX FOR APPELLANT, filed. (SD-2/19-M) scg
March 25, 1985	5.	Appellees' motion for an extension of time (to and including May 3, 1985) to file their brief, filed. (SD-3/21-M) (ejc) GRANTED: 3/26/85—No further extensions should be expected. (bam)
March 26, 1985	6.	Appellees' motion for an extension of time to file brief (to & including May 3, 1985), filed. (SD-3/21-M). (bam) GRANTED: 3/28/85. (bam)
April 29, 1985		BRIEF FOR APPELLEE, filed. (dm) (SD 4/26-85 M)
May 8, 1985	7.	Appellant's motion for an extension of time to file reply brief (to & including May 20, 1985), filed. (SD-5/7-M). (bam) GRANTED: May 13, 1985. (ejc)
May 8, 1985		*Letter to counsel re oral argument on June 5/6. df*
May 21, 1985		REPLY BRIEF FOR APPELLANT, filed. (SD-5/20-M) (ejc)

June 4, 1985	8.	Appellee's citation of add'l authority, received. (Circulated to panel 6/4/85) (ejc)
June 5, 1985		ARGUED BEFORE FRIEDMAN, RICH, BISSELL. (AMM)
September 19, 1985		AFFIRMED. Bissell, J. (U) ak
October 11, 1985		MANDATE ISSUED TO THE CLAIMS COURT. (rs)
Dec. 12, 1986 [*sic*]	9.	Extension of time granted by Chief Justice on Dec. 10, 1985, to the appellant, to & including Feb. 16, 1986, within which to file its writ of certiorari in the Supreme Court. (scg) (A-446)
Feb. 18, 1986		PETITION FOR CERTIORARI FILED IN THE SUPREME COURT. (85-1385) scg GRANTED: 6-16-86. mym
July 18, 1986	10.	Letter from S.Ct. requesting record be transmitted, received. df
July 22, 1986		Copy of CAFC docket entries, opinion of 9/19/85 and appendix filed 2/2/86 certified and hand delivered to S.Ct. (df)

UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORP., ET AL.,

v.

UNITED STATES OF AMERICA,

RELEVANT DOCKET ENTRIES

Jan. 2, 1981	Filing fee of $10 paid by plaintiffs.
Feb. 5, 1981	Notice of reference to Trial Judge Robert M. M. Seto filed. Copy to parties.
Mar. 9, 1981	Defendant's motion for extension of time (to April 8, 1981) to file answer, etc. filed. Copies (2) to atty. ALLOWED: MAR 11 1981.
Apr. 8, 1981	Defendant's motion for extension of time (to May 8, 1981) to file it answer, etc. filed. Copies (2) to atty. ALLOWED: APR 13 1981.
May 8, 1981	Defendant's answer filed. Copies (5) to atty.
Feb. 22, 1982	Trial Judge's standard pretrial order on liability (Rule 111) filed. Copy to parties. [Submission: April 23, 1982]
Apr. 12, 1982	Plaintiff's motion for extension of time (to May 23, 1982) to comply with pretrial order filed. Copies (2) to deft. ALLOWED: APR 13 1982 with no further

	extension to be granted except for extraordinary circumstances.
Jun 23, 1982	Defendant's motion for extension of time (to August 22, 1982) to comply with pretrial order filed. Copies (2) to atty. ALLOWED: JUN 24 1982
Aug. 23, 1982	Defendant's motion for extension of time (to OCT 21 1982) to file pretrial submission filed. Copies (2) to atty. ALLOWED: SEP 9 1982
Oct. 21, 1982	Defendant's motion for extension of time (to December 20, 1982) to comply with pretrial order filed. Service by mail: 10/21/82. ALLOWED: NOV 10 1982, with no further extensions.
Feb. 16, 1983	Order entered scheduling trial date. Copy to parties.
Jul 20, 1983	Plaintiffs' motion for substitution of attorney of record [from Herbert B. Olfson (who consents) to Lynne E. McNown] filed. Service by mail: 7/18/83.
Aug. 15, 1983	Plaintiffs' motion for ruling on procedural matters filed. Service by mail: 8/9/83. ALLOWED: SEP 6 1983.
Aug. 26, 1983	Defendant's response to plaintiff's motion for ruling on procedural matters filed. Service by mail: 8/26/83.
Sep. 1, 1983	Plaintiffs' clarification of its motion for ruling on procedural matter filed [by leave of the judge]. Service: 8/26/83.
Sep. 8, 1983	Stipulation of facts filed by pltf.
Sep. 20, 1983	Plaintiffs' trial memorandum filed [by leave of the Judge]. Service: 9/8/83.

Sep. 28, 1983	Judge's post-trial order filed. Copy to parties. [Pltf.'s principal brief due: 30 days after filing of transcript—30—20. (Proposed findings of fact and objections shall not be counted in determining length of briefs under Rule 83.1(b)).]
Oct. 17, 1983	Transcript of proceedings (3 volumes) taken at St. Louis, Missouri, on September 12 through 14, 1983; together with plaintiff's exhibits 1 through 47; and defendant's exhibits 1 through 12, and 15 through 21, filed. Notice to parties.
Nov. 3, 1983	Plaintiff's motion for leave to exceed page limitation (by 5 pages filed. Service by mail: 11/3/83. ALLOWED BY ORDER OF JAN 16, 1984
Nov. 16, 1983	Plaintiffs' proposed findings of fact and post-trial brief [two separate documents] filed. Service by mail: NOV 16 1983.
Dec. 15, 1983	Defendant's proposed findings of fact, conclusions of law, and objections to plaintiffs' proposed findings of fact and conclusion of law filed. Service by mail: 12/15/83.
Dec. 15, 1983	Defendant's brief filed. Service by mail: 12/15/83.
Jan. 6, 1984	Plaintiffs' objections to defendant's proposed findings of fact and conclusions of law filed. Service by mail: 1/6/84.
Jan. 6, 1984	Plaintiffs' reply brief filed. Service by mail: 1/6/84.

Jan. 16, 1984	Judge's order re page limitation filed. Copy to parties.
Sep. 7, 1984	Judge's opinion filed. Copies to parties.
Sep. 10, 1984	Judgment entered that plaintiffs recover the sum of $31,708 plus interest, representing their valid deduction for expenses incurred in 1972. Copy to parties.
Sep. 11, 1984	Certified transcript of judgment forwarded to attorney of record. See correspondence in file.
Nov. 9, 1984	Defendant's notice of appeal filed. Copy to plaintiff and C.A.F.C.

IN THE
UNITED STATES COURT OF CLAIMS

No. 7-81T

GENERAL DYNAMICS CORPORATION, A DELAWARE CORPORATION, STROMBERG-CARLSON CORPORATION, A DELAWARE CORPORATION, DATAGRAPHIX, INC., A DELAWARE CORPORATION, MATERIAL SERVICE CORPORATION, A DELAWARE CORPORATION, AND MARBLEHEAD LIME COMPANY, A DELAWARE CORPORATION, PLAINTIFFS

v.

UNITED STATES OF AMERICA, DEFENDANT

PETITION

[Filed Jan. 8, 1981]

The plaintiffs hereby petition for a refund of taxes paid by them for the year 1972 and as the basis of their claim state as follows:

1. Plaintiff General Dynamics Corporation is a Delaware corporation with its principal office in St. Louis, Missouri.

2. Plaintiff Stromberg-Carlson Corporation is a Delaware corporation with its principal office in Tampa, Florida.

3. Plaintiff DatagraphiX, Inc. is a Delaware corporation with its principal office in San Diego, California.

4. Plaintiff Material Service Corporation is a Delaware corporation with its principal office in Chicago, Illinois.

5. Plaintiff Marblehead Lime Company is a Delaware corporation with its principal office in Chicago, Illinois.

6. Defendant is the United States of America.

7. This action arises under the Internal Revenue Code of 1954. The jurisdiction of this Court is based upon 28 U.S.C. § 1491.

8. In 1972, plaintiffs Stromberg-Carlson Corporation, DatagraphiX, Inc., and Material Service Corporation were, and they still are, wholly owned subsidiaries of plaintiff General Dynamics Corporation. In 1972, plaintiff Marblehead Lime Company was, and it still is, a wholly owned subsidiary of plaintiff Material Service Corporation. In 1972, Freeman Coal Mining Corporation ("Freeman"), an Illinois corporation, and The United Electric Coal Companies ("United"), a Delaware corporation, were wholly owned subsidiaries of Material Service Corporation. After 1972, Freeman and United were merged into Material Service Corporation.

9. For the calendar year 1972, plaintiffs, Freeman and United (collectively referred to herein as "taxpayers") filed a consolidated income tax return.

10. The taxpayers use the accrual method of accounting. As accrual basis taxpayers, under § 461(a) of the Internal Revenue Code of 1954 and § 1.461-1(a)(2) of the regulations promulgated under the Code, the taxpayers deduct expenses, not when actually paid, but rather in the taxable year in which all the events have occurred which determine the fact of the liability and the amount thereof can be determined with reasonable accuracy.

11. Beginning in October 1972, the taxpayers became self-insurers under plans of medical care benefits provided their employees and the employees' dependents. The benefits vary by location, but essentially cover hospitalization, surgery, dental and major medical costs. Employees at each location are furnished a booklet or other information describing the benefits available. The program is ad-

ministered by Aetna Life Insurance Company ("Aetna") and the Prudential Insurance Company of America ("Prudential"). These companies formerly insured the program, the premiums for which the taxpayers deducted under their accrual method of accounting.

12. There is a lag between the time medical treatment, such as for hospitalization or surgery, is received by an employee or his dependent and the time the employee's costs for the medical treatment are paid by the taxpayers. When an employee receives medical treatment covered by one of the plans, he submits a health expense benefit claim form. The claims are checked to verify employment and coverage, processed, and paid according to the published benefit schedule.

13. For 1972 and subsequent years, the taxpayers established accrual/reserve accounts to reflect the taxpayers' liability for medical services rendered to employees and their dependents during the year but unpaid at year-end. The amount of the accrual/reserve accounts are determined by taking a percentage, which is supplied by Aetna and Prudential, of the payments made by the taxpayers in a prior period. The percentages are based on the weighted average lag in time in the prior period between incurral of the medical services and payment by the taxpayers. The determination of the amount of the accrual/reserve accounts is made substantially as follows:

1) Number of days between date of incurral of medical services and date of payment by taxpayers	=	Days Time Lag
2) Amount of each payment multiplied by Days Time Lag	=	Weighted Lag
3) Weighted Lag divided by total payments	=	Weighted Average Day Lag Per Payment
4) Weighted Average Day Lag Per Payment divided by total days in period	=	Percentage of Period Lag Per Payment

5) Percentage of Period Lag = Total accrual/reserve Per Payment multiplied by total payments in prior period

This method can be illustrated as follows:

	Payments		Days Time Lag		Weighted Lag	
1)	$ 50	×	30	=	1,500	
	100	×	60	=	6,000	
	50	×	10	=	500	
	$ 200				8,000	
2)	8,000	=	40			
	200					
3)	40	=	10.96%			
	365					
4)	10.96%	×	$200	=	$21.92	Total accrual/ reserve

14. At December 31, 1972, the taxpayers' accrual/reserve accounts for medical services included the amount of $5,601,689 which was the taxpayers' reasonable determination of the amount of their liability for medical treatment provided their employees and the employees' dependents during the year which had not been paid by the end of the year. During 1973 and 1974, the taxpayers actually paid 87.9% of this amount for medical services rendered to their employees and the employees' dependents in 1972.

15. Under the taxpayers' medical care benefit plans, the taxpayers were liable to pay medical care benefit payments when the following three events had occurred: (A) the employee was covered by a medical care benefit plan, (B) the employee or his dependent had received medical services, and (C) those services were included in the plan of benefits available under the medical care benefit plan. The last event to occur which determined the fact of the taxpayers' liability was the rendition of the medical services.

16. The 1972 year-end accrual of $5,601,689 was only for medical services which had been rendered in 1972; no part of that accrual was for medical services to be rendered in a future year. The amount of the accrual was determined with reasonable accuracy based upon the taxpayers' past experience. The taxpayers were entitled to deduct the amount of $5,601,689 for medical treatment provided to the taxpayers' employees and their dependents during 1972 which had not been paid, since all of the events which determined the fact of liability had occurred in 1972 and the amount of that liability was determined with reasonable accuracy. Failure to allow a deduction for the accrual of this liability in 1972 and postponement of the deduction to the years subsequent to 1972 in which the liability was paid would distort the taxpayers' income for 1972 and would make these accrual basis taxpayers operate on cash basis accounting principles in regard to these expenses.

17. On or about September 15, 1973, the plaintiffs timely filed their consolidated income tax return for 1972. The plaintiffs did not deduct the $5,601,689 on that return. All income taxes due for 1972 have been paid.

18. On or about February 22, 1977, the plaintiffs filed a timely and proper claim for refund for 1972 with the Internal Revenue Service, which was amended on or about September 21, 1978, claiming, *inter alia,* a deduction for the $5,601,689 and a refund of $31,708 plus interest.

19. On or about January 26, 1979, the plaintiffs executed Form 3363 (Acceptance of Proposed Disallowance of Claim for Refund or Credit) and Form 2297 (Waiver of Statutory Notification of Claim Disallowance) in respect of their claim for refund for 1972.

20. The deduction of $5,601,689 is proper and should have been allowed. By reason of the plaintiffs' failure to deduct the $5,601,689 on their original 1972 tax return, the plaintiffs have in fact paid more than the proper amount

of income tax due for 1972. After adjustments (including an offset for the recognition of substantial additional income under various long-term contracts as a result of the additional deductible expenses), the tax refund resulting from the deduction of $5,601,689 is $32,001.

WHEREFORE, the plaintiffs pray that this Court:

1. Enter judgment in favor of plaintiffs for $31,708 plus interest as provided by law. .

2. Grant such other or further relief as may be appropriate.

GENERAL DYNAMICS CORPORATION
STROMBERG-CARLSON CORPORATION
DATAGRAPHIX, INC.
MATERIAL SERVICE CORPORATION
MARBLEHEAD LIME COMPANY

By _____

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IN THE UNITED STATES COURT OF CLAIMS

No. 7-81 T

GENERAL DYNAMICS CORPORATION, ET AL., PLAINTIFF

v.

THE UNITED STATES, DEFENDANT

ANSWER

[Filed May 8, 1981]

For its answer to the petition, defendant respectfully denies each and every allegation contained therein, not admitted, qualified, or expressly referred to below:

Defendant further:

1-7. Admits the allegations contained in paragraphs 1 through 7.

8-9. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraphs 8 and 9.

10. Admits the allegations contained in paragraph 10, but states that Section 461(a) of the Internal Revenue Code and the regulations thereunder speak for themselves.

11. Admits the allegations contained in paragraph 11.

12. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph 12.

13. Admits the allegations contained in the first sentence of paragraph 13, but states that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in the remainder of this paragraph.

14-15. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraphs 14 and 15.

16. States that its attorneys are presently without knowledge or information sufficient to form a belief as to the truth of the allegations contained in the first sentence of paragraph 16, but denies the allegations contained in the remainder of this paragraph.

17. Admits the allegations contained in paragraph 17.

18. Admits the allegations contained in paragraph 18, but denies that this amended claim for refund claimed a "proper" deduction.

19. Admits the allegations contained in paragraph 19.

20. Denies the allegations contained in paragraph 20.

WHEREFORE, defendant prays that the petition be dismissed with allowable costs assessed against plaintiff.

Respectfully submitted,

/s/ JOHN F. MURRAY
John F. Murray
Acting Assistant Attorney General

/s/ MARC LEVEY
Marc Levey
Attorney

IN THE UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORPORATION, ET AL., PLAINTIFF

v.

THE UNITED STATES, DEFENDANT

STIPULATION OF FACTS

[Filed Sep. 8, 1983]

Plaintiffs General Dynamics Corporation, Stromberg-Carlson Corporation, DatagraphiX, Inc., Material Services Corporation and Marblehead Lime Company, by their attorney, and defendant United States, by its attorney, stipulate for the purposes of this proceeding that the following statements of fact are true and correct.

As used herein, "taxpayers" shall refer to the plaintiffs, Freeman Coal Mining Corporation and The United Electric Coal Companies; "Prudential" shall refer to The Prudential Insurance Company of America; and "Aetna" shall refer to the Aetna Life Insurance Company.

1. Plaintiff General Dynamics Corporation is, and at all relevant times has been, a Delaware corporation with its principal office in St. Louis, Missouri.

2. Plaintiff Stromberg-Carlson Corporation is, and at all relevant times has been, a Delaware corporation. Its principal office was in Rochester, New York in 1972, and now is in Orlando, Florida.

3. Plaintiff DatagraphiX, Inc. is, and at all relevant times has been, a Delaware corporation with its principal office in San Diego, California.

4. Plaintiff Material Service Corporation is, and at all

relevant times has been, a Delaware corporation with its principal office in Chicago, Illinois.

5. Plaintiff Marblehead Lime Company is, and at all relevant times has been, a Delaware corporation with its principal office in Chicago, Illinois.

6. In 1972, plaintiffs Stromberg-Carlson Corporation, DatagraphiX, Inc. and Material Service Corporation were, and they still are, wholly owned subsidiaries of plaintiff General Dynamics Corporation. In 1972, Marblehead Lime Company was, and it still is, a wholly owned subsidiary of plaintiff Material Service Corporation. In 1972, Freeman Coal Mining Corporation ("Freeman"), an Illinois corporation, and The United Electric Coal Companies ("United"), a Delaware corporation, were wholly owned subsidiaries of Material Service Corporation. After 1972, Freeman and United were merged into Material Service Corporation.

7. For the calendar year 1972, plaintiffs, Freeman and United (separately referred to herein as "taxpayer" or collectively as "taxpayers") filed a consolidated federal income tax return.

8. In 1972, the taxpayers used the accrual method of accounting. As accrual basis taxpayers, the taxpayers deducted expenses, not when actually paid, but rather in the taxable year in which all the events had occurred which determined the fact of the liability and the amount of the liability could be determined with reasonable accuracy.

9. In 1972 and for many years prior thereto and for all of the years since then, the taxpayers had established plans pursuant to which they provided extensive medical care benefits for non-occupational sickness or injury (referred to herein as "medical care benefits") to their employees and the employees' qualified dependents. These medical care benefit programs were provided as part of the consideration paid by the taxpayers for their employees' services; these programs were fringe benefits which employees received along with wages and other benefits for their labor.

10. Under the self-insured medical care benefit plans, as part of the terms and conditions of employment of those employees specified as eligible in the plans, the taxpayer promised to pay for the medical care treatment specified in the applicable plan which was received by the employee or the employee's qualified dependent while the employee was employed, according to the benefit schedules stated in the applicable plan.

11. The cost of providing these medical care benefits to their employees were ordinary and necessary business expenses of the taxpayers.

12. For the years prior to 1972 and for most of 1972, the taxpayers provided the medical care benefits by purchasing group medical insurance for the employees and their qualified dependents. For at least ten years up through 1972, this insurance coverage was purchased from two insurance companies: Aetna Life Insurance Company ("Aetna") and The Prudential Insurance Company of America ("Prudential").

13. Aetna basically handled the insurance coverage for the medical care benefits for certain facilities of General Dynamics Corporation (Convair—San Diego, Convair—Ft. Worth, Electronics—San Diego and Dynatronics, and Pomona), for certain facilities of Stromberg-Carlson Corporation (Ardmore, Sanford and Camden) and for Stromberg DatagraphiX, Inc.

14. Prudential basically handled the insurance coverage for the medical care benefits for certain facilities of General Dynamics Corporation (Corporate Office, Electric Boat, Electro Dynamic/Avenel, Electronics—Rochester, and Quincy), for certain facilities of Stromberg-Carlson Corporation (Rochester and Charlottesville), and for Material Service Corporation, Marblehead Lime Company, Freeman and United.

15. The taxpayers were charged premiums for the medical care benefit insurance purchased from Aetna and Pru-

dential. Those premiums were deducted as expenses on the taxpayers' consolidated federal income tax returns. The premiums charged by the insurance companies included amounts for medical services which had been rendered in the policy year but for which claims had not yet been paid.

16. In the latter part of 1972, the taxpayers became self-insurers of their medical care benefit plans. Except for the Fort Worth and the Electric Boat facilities of General Dynamics Corporation, the change to self-insurance was effective on October 1, 1972. The Fort Worth and Electric Boat facilities changed to self-insurance for the medical care benefit plans effective on December 1, 1972.

17. The change to self-insurance in 1972 did not cause a change in the medical care benefits being provided by the taxpayers to their employees. The change to self-insurance merely terminated the insurance coverage for these benefits which the taxpayers had previously obtained from Aetna and Prudential. Effective with the change to self-insurance, the taxpayers (and not Aetna and Prudential) were liable for the costs of providing the medical care benefits.

18. Plaintiffs' Exhibit 1 is a true and correct copy of an Agreement between General Dynamics Corporation and Prudential, which was signed in October, 1972.

19. Plaintiffs' Exhibit 2 is a true and correct copy of an Agreement between General Dynamics Corporation and Prudential, dated December 1, 1972.

20. Plaintiffs' Exhibit 3 is a true and correct copy of the Reserve Refund Agreement between General Dynamics Corporation and Aetna, dated in September, 1972.

21. The taxpayers hired Aetna and Prudential to administer the self-insured medical care benefit plans. Each insurance company continued to service the facilities of the taxpayers for which it had previously provided insurance coverage for the medical care benefit plans.

22. Plaintiffs' Exhibit 4 is a true and correct copy of the

Administrative Services Agreement between General Dynamics Corporation and Prudential, effective October 1, 1972.

23. Plaintiffs' Exhibit 5 is a true and correct copy of the Administrative Services Contract between General Dynamics Corporation and Aetna, effective October 1, 1972.

24. Aetna and Prudential have administered the self-insured medical care benefits plans for the taxpayers from October 1, 1972 to date.

25. Each taxpayer notified its employees of the change to self-insurance by the taxpayer for the medical care benefits.

26. Plaintiffs' Exhibit 6 and Plaintiffs' Exhibit 7 are true and correct copies of announcement letters of the change to self-insurance which were distributed around October and December, 1972, respectively, to General Dynamics Corporation employees whose medical care benefits had been insured by Prudential. Plaintiff's Exhibit 8 is a true and correct copy of a letter dated November 27, 1972, which was sent on or about that date by D. C. Wilkens, Jr., Director of Industrial Relations of the Electric Boat Division of General Dynamics Corporation, to Herbert S. Searle, President of the Marine Draftsmen's Association.

27. In 1972, the medical care benefits provided by the taxpayers under the plans varied somewhat by facility but essentially covered hospitalization, surgery, dental and major medical costs incurred by an employee or his qualified dependent during the time that the employee was employed by a taxpayer.

28. Each self-insured medical care benefit plan described the employees and the dependents covered by the plan. Each plan described the nature and extent of the benefits provided under the plan, including a description of the services and the supplies and amounts which would be paid.

29. Employees at each facility of the taxpayers were furnished a booklet which summarized the provisions of the plan and the benefits which were covered under the plan for that particular facility. These booklets were periodically revised or supplemented to set forth changes in plan provisions and benefits.

30. Plaintiffs' Exhibit 9 is a true and correct copy of the portion of the employee booklet setting forth the medical care benefit plan in effect in December, 1972 (after the change to self insurance), at the Electric Boat facility of General Dynamics Corporation for certain union employees (*i.e.*, those represented by the Patternmakers Association of New London, Connecticut), which booklet was distributed to the appropriate employees around December, 1972.

31. Plaintiffs' Exhibit 40 is a true and correct copy of a portion of the employee booklet setting forth the medical care benefit plan in effect in October, 1972 (after the change to self insurance), at the Ardmore facility of Stromberg-Carlson Corporation for salaried employees, which booklet was distributed to the appropriate employees around October, 1972.

32. The plans of medical care benefits set forth in Plaintiffs' Exhibits 9 and 40 are typical of the plans which were in effect at that time at the other facilities of the taxpayers.

33. Under the self-insured plans, the taxpayers were required to pay for those medical services described in the plan which were rendered to covered employees and qualified dependents. If a covered employee's employment were terminated after the rendition of covered medical services to the employee or a qualified dependent, the employee retained the rights which he had under the plan that the taxpayer pay for those services even if a claim for payment had not been filed before such termination of employment. Similarly, if medical services were received by a qualified dependent and the claim was not filed until after

the dependent ceased to be a qualified dependent, the employee retained his rights under the plan to require payment for those medical services.

34. When an employee or his qualified dependent had received medical treatment covered by a plan, the employee obtained payment for the medical services rendered by filling out and submitting a health expense benefits claim form. These forms underwent a regular processing procedure and were paid according to the terms of the particular plan.

35. Plaintiffs' Exhibit 10 is a true and correct copy of the type of claim form used by the taxpayers in the early 1970's in connection with the medical care benefits plans. The claim form contained pertinent information about the employee and, if applicable, the dependent. It stated necessary information regarding the treatment and services received, including the dates for each medical service or expense, and the cost. Itemized bills were submitted with the claim form.

36. The completed claim forms were submitted to appropriate industrial relations personnel at each facility. The forms were checked against personnel records to verify that the employee or dependent was covered by the particular plan at the time of the treatment. The form was also checked for completeness. If additional information was necessary, it was requested. If the claim was ineligible because the employee or dependent was not covered by the plan at the time of treatment, the processing would stop and the employee would be informed that the claim was not eligible. Such ineligible claims were not sent on to Aetna or Prudential.

37. Eligible claims were then processed further and paid according to the terms of the plans, either by reimbursing the employee or by paying the service provider (such as a hospital) directly.

38. Claims from the taxpayers' facilities administered by

Aetna were sent to the appropriate Aetna claims office for further processing and payment. In these claims offices, Aetna had a staff of claims handlers who were qualified and experienced in the handling of medical care benefit claims. Typically, certain individuals in an Aetna claims office would be familiar with the taxpayers' medical care benefits plans and would handle the processing of the claims submitted by the taxpayers' employees. The Aetna claims personnel calculated the amount of the benefit payments according to the schedules and formulas set forth in the plans.

39. Eligible claims at the taxpayers' facilities administered by Prudential, which facilities did not process their own claims, were sent to Prudential for final processing. Prudential had a staff of claims handlers who were experienced and qualified to process medical care benefit claims. The Prudential claims personnel calculated the amount of the benefit payments according to the schedules and formulas set forth in the plans.

40. At its Quincy and Electric Boat facilities, General Dynamics Corporation had its own staff of experienced, qualified claims personnel who completed the processing and calculated the benefit payments. Prudential's personnel consulted with the Quincy and Electric Boat claims personnel on claims whenever such consultation was needed. Prudential periodically visited these facilities and audited the claims handling performed by the Quincy and Electric Boat facility personnel to determine that claims were being handled properly under the applicable plans.

41. To pay claims, Aetna issued drafts on one of its accounts at the Hartford National Bank. An automatic transfer of funds was made each day from a General Dynamics Corporation account to the Aetna account to cover the drafts cleared through the Aetna account that day. For the facilities administered by Prudential, claims were paid by issuing General Dynamics Corporation drafts.

42. In 1972, The taxpayers had approximately 56,000 employees in the aggregate. Thousands of claims were filed by the taxpayers' employees for payment for medical services, which services had been rendered in 1972. The claims handling process, whether handled by Aetna, Prudential or General Dynamics Corporation, was performed by experienced claims-handling personnel; the process was a matter of established procedures. The plans specified the benefits which were payable. For many items, the plan had a specific dollar amount which was paid. For example, surgical procedures were listed in considerable detail with the specific allowable dollar amounts specified. When a plan provided for a semiprivate room, the claims personnel had current data on the rates for such rooms at hospitals in the area. The major medical benefits were the subject of a set formula.

43. The taxpayers' obligation to pay according to the terms of the plans for the medical care benefits received by covered employees and their qualified dependents was a matter of contract between the employees and taxpayers. The taxpayers' obligation to pay for medical care benefits did not rest upon any determination of fault or wrongdoing.

44. The taxpyers' experience under the self-insured plans has been that, except for rare instances, employees did not contest the disposition of their medical care benefit claims. An explanation of the calculation of a benefit payment is furnished to each employee, giving reasons for amounts which are not covered and thus are not paid.

45. Employees did on occasion have questions pertaining to the benefit calculations and the payments made, but almost all of these questions were resolved by rechecking the calculation and explaining the coverage of the particular plan. In those instances when an employee raised a matter of substance regarding the benefit calculation, the appropriate personnel at the taxpayers, Aetna or Pruden-

tial reviewed the matter further and made a final decision which would conclude the matter except in an extremely small number of instances.

46. There was a lag between the time that the medical services were rendered to an employee or his dependent and the time the employee's costs for the services were paid by the taxpayers. At December 31, 1972, taxpayers had not received all of the claim forms which they would receive for medical treatment services rendered in 1972 to covered employees and qualified dependents. Additionally, claims for medical services rendered in 1972 had been filed by December 31, 1972 but had not yet been completely processed and paid.

47. The taxpayers sought advice from Aetna and Prudential regarding how to reasonably determine the amount of their liability for medical services rendered to employees and qualified dependents but unpaid by the taxpayers at any given time. Aetna and Prudential advised the taxpayers that the amount of that liability could be reasonably determined by taking a percentage of the payments made by the taxpayers for medical care benefits in a prior period, and they supplied the taxpayers with the relevant percentages. The Aetna percentages were to be applied to the payments made in the prior three-month period. The Prudential percentage figure was to be applied to the payments made in the prior twelve-month period. Periodically, Aetna and Prudential provided the taxpayers with such paid-claim information.

48. Prudential's analysis consisted of a study of the taxpayers' experience regarding the actual lag between the incurral and payment of claims and produced a single percentage to be applied to the aggregate of all paid claims without differentiating categories of benefits. By studying the actual lag between incurral and payment of claims for a twelve-month period, Prudential believed that it could determine the percentage of a year's paid claims which rep-

resented the incurred but unpaid claims. In this study, a weighted average number of days lag per claim was derived by averaging both the number of days lag for each claim and the amount of each payment. The weighted average number of days was then divided by 365 to determine a percentage lag factor.

49. Aetna's percentages were Aetna's standard lag factors for each of the four categories of medical care benefits. These standard lag factors were derived by Aetna's actuaries' study of Aetna's experience regarding the actual lag between incurral and payment of claims for its entire book of medical care benefit plans (both insured and uninsured). By studying the actual lag between incurral and payment of claims, Aetna believed that it could determine the percentage of a given amount of paid claims which represented the incurred but unpaid claims at a given time. In this study, claims were grouped by month of incurral and then analyzed to determine the amounts and percentages of those claims which were paid in the first month and each of the following months. The analysis of twelve months of incurred claims was then combined and adjusted, among other things, for inflation and for application to the amount of claims paid in a three-month period.

50. Plaintiffs' Exhibit 11 is a true and correct copy of a letter dated October 17, 1972 from Jeremiah Kelly of Prudential to Robert A. Bussey, Corporate Insurance Manager of General Dynamics Corporation, which was sent on or about that date.

51. Plaintiffs' Exhibit 12 is a true and correct copy of a letter dated October 26, 1972 from James D. Holland of Aetna which was sent on or about that date to R. A. Bussey, Corporate Insurance Manager of General Dynamics.

52. For the calendar year 1972, the taxpayers established accrual/reserve accounts to reflect the liability which they thought they had under the plans for medical services

rendered to employees and their qualified dependents. The accounting departments at each division and subsidiary established a balance in the account at year-end (December 31, 1972) to reflect the liability which that division or subsidiary believed that it had for medical services rendered to employees and their qualified dependents during 1972 but unpaid at December 31, 1972. The amounts referred to in the prior sentence were determined as follows:

A. Corporate Office: The balance at December 31, 1972 of $25,828.19 for Prudential was calculated by taking the total drafts issued for Corporate Office medical claims (insured and service contract) for the period January through December, 1972—$95,695.41—and multiplying that total by 26.99%. The balance at December 31, 1972 of $640 for Aetna was the amount of reserves attributable to the Corporate Office for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance.

B. Fort Worth: The balance at December 31, 1972 of $1,388,728 was calculated by taking the amount of reserves attributable to Fort Worth for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$1,115,862—and then adding an accrual for December, 1972 as a provision for additional expenses for medical care benefits (derived by multiplying an expense accrual rate for health care per individual for Fort Worth by the number of persons covered)—$497,308.99—and then subtracting the drafts for medical benefits which had cleared in December, 1972—$224,443.13.

C. Convair—San Diego: The balance at December 31, 1972 of $1,756,619 for Aetna was calculated by taking the amount of reserves attributable to Convair—San Diego for the medical care plan which were returned by Aetna when the taxpayers switched to self-insurance—$1,462,134—and then adding an accrual for October

through December, 1972 as a provision for additional expenses for medical care benefits (derived by multiplying an expense accrual rate for health care per individual for Convair by the number of persons covered)—$1,307,117—and then subtracting the drafts for medical benefits which had cleared in the October through December, 1972 period—$955,618—and subtracting fees for that period for administration of the service contract by Aetna—$50,551—and then subtracting a figure to discount the reserve by a 6% factor for a present value allowance—$6,463. The balance at December 31, 1972 of $493 for Prudential was calculated by taking the reserves attributable to Convair—San Diego which were returned by Prudential—$319—and adding a provision for additional expenses.

D. Electric Boat: The balance at December 31, 1972 of $1,235,467.47 was calculated as follows. An amount—$1,055,879—as a reserve for incurred but unpaid claims was determined by multiplying the total payments for Electric Boat medical claims (insured and service contract) for the period December, 1971 through November, 1972—$3,912,114—by 26.99%. A provision for additional medical care expenses for December, 1972—$336,164—was added; this amount was derived by multiplying an expense accrual rate for health care per individual for Electric Boat by the number of persons covered ($74,526 of this amount was from employee contributions by payroll deductions). Then the charges to the account for drafts issued in December, 1972 were subtracted—$156,576.53.

E. Quincy: The balance at December 31, 1972 of $715,000 was calculated by taking the total drafts issued for Quincy medical claims (insured and service contract) for the period January through December, 1972—$2,647,970—and multiplying that total by 26.99% and rounding up to the next $1,000.

F. Electro Dynamic/Avenel: The balance at December

31, 1972 of $21,574 was calculated by taking the total of medical care benefit payments for Electro Dynamic/Avenel for the period December, 1971 through November, 1972 and multiplying that total by 26.99%.

G. Pomona: The balance at December 31, 1972 of $595,727.57 for Aetna was calculated by taking the amount of reserves attributable to Pomona for the medical care plan which were returned by Aetna when the taxpayers switched to self-insurance—$375,150—and then adding an accrual for the period October through December, 1972 as a provision for additional expenses for medical care benefits—$593,508.90—and then subtracting the drafts for medical benefits which had cleared in the period October through December, 1972—$372,931.33. The balance at December 31, 1972 for Prudential of $32 was the amount of reserves attributable to Pomona returned by Prudential.

H. Electronics: The balance at December 31, 1972 of $334,617 for Aetna was calculated by taking the amount of the reserves attributable to Electronics for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$256,064—and then adding an accrual for the period October through December, 1972 as a provision for additional expenses for medical care benefits—$257,600—and then subtracting the drafts for medical benefits which had cleared in the period October through December, 1972—$179,048. The balance at December 31, 1972 of $578 for Prudential was calculated by taking the reserves returned by Prudential—$502—and then adding a provision for monthly expenses for medical benefits for the period October through December, 1972—$315—and then subtracting drafts which had been paid in the period—$238.

I. Freeman Coal: The balance at December 31, 1972 of $30,199.43 was calculated by taking the total payments for medical benefits for Freemen Coal for the year 1972—

$111,891.20—and multiplying that total by 26.99%.

J. Marblehead Lime: The balance at December 31, 1972 of $37,839 was calculated by taking the medical benefit payments for Marblehead Lime for the period July, 1971 through June, 1972—$140,196—and multiplying that total by 26.99%.

K. Material Service: The balance at December 31, 1972 of $85,321 was calculated by taking the medical benefit payments for Material Service for the period January through December, 1972—$316,121—and multiplying that total by 26.99%.

L. United Electric Coal: The balance at December 31, 1972 of $10,371.45 was calculated by taking the medical benefit payments for United Electric Coal for the year 1972—$38,427.01—and multiplying that total by 26.99%.

M. Stromberg-Carlson: The balance at December 31, 1972 of $80,036 for Aetna was calculated by taking the amount of reserves attributable to Stromberg-Carlson for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$71,321—and then adding a provision for additional expenses for medical care benefits for the period October through December, 1972—$59,138—and then subtracting the drafts for medical benefits which had cleared in the period October through December, 1972—$50,423. The balance at December 31, 1972 of $96,551 for Prudential was calculated by taking the amount of reserves for medical care benefits attributable to Stromberg-Carlson which were returned by Prudential—$141,258—and then adding a provision for additional monthly expenses for medical care benefits for the period October through December, 1972—$54,075—and then subtracting the drafts which were issued for medical benefits in the period October through December, 1972—$60,964—and subtracting $37,818 which was reclassified into another liability account.

N. DatagraphiX: The balance at December 31, 1972 of $65,478 was calculated by taking the amount of reserves attributable to DatagraphiX for the medical care plan which were returned by Aetna when the taxpayers switched to self insurance—$64,954—and then adding an accrual for the period October through December, 1972 as a provision for additional expenses for medical care benefits—$56,040—and then subtracting the drafts for medical benefits which had cleared in the October through December, 1972 period—$52,727—and subtracting the Aetna administrative service fee for that period—$2,789.

The monthly provision for additional expenses for medical care benefits referred to in the preceding subparagraphs was derived by multiplying an expense accrual rate for health care benefits per individual (which rate was provided by the applicable insurance company) by the number of persons covered by the benefits at the facility. The references to balances for Prudential and Aetna in the preceding subparagraphs are to the self-insured plans administered by each company.

53. Plaintiffs' Exhibits 13 through 26 are schedules prepared and submitted by the divisions and subsidiaries of General Dynamics Corporation in 1973 to the General Dynamics Corporation corporate office, which schedules analyze the accrual/reserve account for self-insured medical benefit plans for each unit for the year 1972 and set forth the balance in the account at December 31, 1972.

54. Plaintiffs' Exhibit 27 is a schedule prepared in 1973 analyzing the medical care benefit self-insurance accrual/reserve account of General Dynamics Corporation as a whole and its divisions for the year 1972 with the December 31, 1972 balances in the account.

55. The balance in the accrual/reserve accounts for medical care benefits at December 31, 1972, without adjustments was $6,481,099.

56. There were drafts for medical care benefits which

were issued and outstanding but which had not cleared the system and been paid by the taxpayers' funds at December 31, 1972 in the amount of $501,277. These had not been charged to the accrual/reserve account by December 31, 1972. The balance in the accrual/reserve accounts as of December 31, 1972 (after adjusting for the outstanding drafts) was $5,979,822.

57. Plaintiffs' Exhibit 28 is a true and correct copy of a letter dated June 28, 1973 from James D. Holland, which he sent to General Dynamics Corporation on or about that date, setting forth the amount of issued drafts for the taxpayers' medical care benefits as of December 31, 1972 as reflected on Aetna's books but which had not yet been paid.

58. The balance of $5,979,882 in the medical care benefits accrual/reserve account was taken as an adjustment on Schedule M of the taxpayers' consolidated federal income tax return for 1972. This amount was carried as a liability on the books of the taxpayers at December 31, 1972, but was not deducted on the taxpayers' consolidated 1972 federal income tax return.

59. The balance of $5,979,822 in the taxpayers' accrual/reserve account as of December 31, 1972 included a provision for certain extended liability features under the medical care benefit plans administered by Aetna. The extended liability feature was a provision under the major medical plans which provided that, if a family member was totally disabled by reason of a non-occupational injury or disease on the date his coverage terminated, either because of termination of employment or termination of the plan, major medical benefits would be extended during the continuance of the disability for up to twelve months. The portion of the taxpayers' accrual/reserve accounts which was for this extended liability feature is not in issue in this case. The reserve amount for such extended liability features at December 31, 1972 was $404,533. The balance

in the accrual/reserve accounts as of December 31, 1972 (after adjusting for the extended liability feature reserve) was $5,575,289.

60. The first two pages of Plaintiffs' Exhibit 29 are a true and correct copy of a letter from Dennis D. Sheehan of Aetna, dated July 26, 1974, which was sent on or about that date to J. A. Hawkins, Director of Employee Services of General Dynamics Corporation, and which sets forth the amount of the reserve for the extended liability feature of the medical care benefit plans administered by Aetna as of December 31, 1972. Page three of Plaintifs' Exhibit 29 is a true and correct copy of a schedule showing the amounts paid in 1973 on the taxpayers' medical care benefit claims which were incurred in 1972 or earlier for the plans administered by Aetna.

61. Aetna prepared a computer printout listing all of the taxpayers' medical care benefit claims paid in 1973 (with the amounts which were paid) on claims incurred in 1972 or earlier for plans administered by Aetna. Plaintiffs' Exhibit 30 is a true and correct copy of pages from that computer printout, with names deleted.

62. Aetna prepared a computer printout listing all of the taxpayers' medical care benefit claims paid in 1974 (with the amounts which were paid) on claims incurred in 1973 or earlier for plans administered by Aetna. Plaintiffs' Exhibit 31 is a true and correct copy of pages from that computer printout, with names deleted. The 1974 computer printout shows that $35,282.69 was paid in 1974 on claims incurred in 1972 or earlier years and that an additional $983.82 was paid in 1973 on such claims.

63. Plaintiffs' Exhibit 32 consists of true and correct copies of schedules prepared by Prudential listing amounts which were paid in 1973 and the first six months of 1974 on the taxpayers' medical care benefit claims administered by Prudential in groups by claim incurral dates. Plaintiffs' Exhibit 33 is a true and correct copy of a schedule pre-

pared by Prudential listing 1972 incurred medical care benefits claims listed on the computer in 1973 but probably paid in 1972.

64. Plaintiffs' Exhibit 34 consists of true and correct copies of pages from the computer printout prepared by Prudential listing medical care benefit claims of the taxpayers paid in 1973, with names deleted. Plaintiffs' Exhibit 35 consists of true and correct copies of pages from the computer printout prepared by Prudential listing 1972 medical care benefit claims listed on the computer in 1973, with names deleted, which claims were probably paid in 1972.

65. Plaintiffs' Exhibit 36 consists of true and correct copies of pages from a computer printout prepared by Prudential listing medical care benefit claims of the taxpayers paid in the first six months of 1974, with names deleted. Plaintiffs' Exhibit 37 consists of true and correct copies of pages from a computer printout prepared by Prudential listing medical care benefit claims of the taxpayers paid in the period July 1, 1974 through July 14, 1975, with names deleted. Prudential's records show that $18,597.91 was paid in the last six months of 1974 and an additional $700.09 was paid in June, 1974 on the taxpayers' medical care benefit claims which were incurred in 1972.

66. The Aetna and Prudential computer printouts show that $5,004,891 was paid out in 1973 on the taxpayers' medical care benefit claims which were incurred in 1972 or earlier and that $80,279 was paid out in 1974 on such claims.

67. A comparison of the year-end balance in the accrual/reserve accounts (adjusted to delete the extended liability portion of the reserve and the drafts which were outstanding)—$5,575,289—and the amounts paid in 1973 and 1974 (adjusted for the drafts outstanding)—$4,583,893—shows that 82.2% of the taxpayers' 1972 year-end accrual/reserve was subsequently paid.

68. On or about September 15, 1973, the taxpayers timely filed their consolidated federal income tax return for 1972. The taxpayers did not deduct the $5,575,289 on that return. All taxes due for 1972 have been paid.

69. On or about February 22, 1977, the plaintiffs filed a timely claim for refund for 1972 with the Internal Revenue Service, which was amended on or about September 21, 1978, claiming, *inter alia,* a deduction for the $5,575,289 and a refund of $31,708 plus interest. Plaintiffs' Exhibit 38 is a true and correct copy of said claim for refund, and Plaintiffs' Exhibit 39 is a true and correct copy of said amendment.

70. On or about January 26, 1979, the plaintiffs executed Form 3363 (Acceptance of Proposed Disallowance of Claim for Refund or Credit) and Form 2297 (Waiver of Statutory Notification of Claim Disallowance) in respect to their claim for refund for 1972.

71. If the taxpayers had calculated their 1972 year-end accrual/reserve balances strictly in accordance with the percentage figures supplied by the insurance companies, the balance in the taxpayers' accrual/reserve accounts for medical care benefits at December 31, 1972 without adjustments would have been $5,888,301 ($3,797,693 for the Aetna plans and $2,090,608 for the Prudential plans) rather than $6,481,099 ($4,221,846 for the Aetna plans and $2,259,253 for the Prudential plans). [See ¶55.]

	Aetna Plans	Prudential Plans	Total
Reserve Balance at 12/31/72 without adjustments	$4,221,846	$2,259,253	$6,481,099
Recalculated Reserve Balance at 12/31/72 without adjustments	3,797,693	2,090,608	5,888,301
Difference	$ 424,153	$ 168,645	$ 592,798

After the adjustments referred to in Paragraphs 56 and 59, the balance in such recalculated accrual/reserve accounts as of December 31, 1972 would have been $4,982,491.

72. At December 31, 1973, the differences between the balances in the accrual/reserve accounts for medical care benefits and the amounts for such reserves recalculated according to the advice of Aetna and Prudential had been substantially eliminated. The balances at December 31, 1973 in such accounts and the recalculated balances are as follows:

	Aetna Plans	Prudential Plans	Total
Reserve Balance at 12/31/73	$3,806,650	$1,916,687	$5,723,337
Recalculated Reserve Balance at 12/31/73	3,777,302	1,928,676	5,705,978
Difference	$ 29,348	[$ 11,989]	$ 17,359

73. Plaintiffs Exhibit 41 sets forth the amounts of claims paid in 1972 and 1973 on the taxpayers' medical care benefit plans administered by Prudential.

74. Plaintiffs Exhibit 42 sets forth the amounts of the recorded claims in July, August and September, 1972 on the taxpayers' medical care benefit plans administered by Aetna.

75. Plaintiffs Exhibit 43 sets forth the calculation of the 1972 year-end accrual/reserve balances had they been calculated by taxpayers strictly in accordance with the percentage figures supplied by Aetna and Prudential.

76. Defendant's Exhibits 1 and 2 are true and correct copies of Prudential claims manuals, which set forth rules, guidelines and procedures provided by Prudential for processing claims attributable to medical treatments and services incurred by persons covered by group health insurance, and for ascertaining whether medical services and

treatments were within the scope of the group health plans, during periods prior to October 1, 1972. They were revised and updated from time to time. These rules, guidelines and procedures (subject to any relevant updates or revisions) are substantially similar to rules, guidelines and procedures provided by Prudential for processing claims attributable to the medical treatments and services incurred by plaintiffs' employees, and for ascertaining whether medical services and treatments were within the scope of plaintiffs' medical care plans, during the period October 1, 1972, through December 31, 1972.

77. Defendant's Exhibits 3 through 6 are true and correct copies of portions of Aetna claims manuals, which set forth rules, guidelines and procedures followed by Aetna in processing claims attributable to the medical treatments and services incurred by plaintiffs' employees, and in ascertaining whether medical services and treatments were within the scope of plaintiffs' medical care plans, during the period October 1, 1972, through December 31, 1972.

78. Defendant's Exhibits 7 through 20 are true and correct copies of Aetna claims letters and interoffice communications.

LYNNE E. MCNOWN	[SIGNATURE]
Attorney for Plaintiffs	Attorney for Defendant

PLAINTIFFS' EXHIBIT 1

AGREEMENT

This Agreement entered into by and between THE GENERAL DYNAMICS CORPORATION (hereinafter called the Policyholder) and THE PRUDENTIAL INSURANCE COMPANY OF AMERICA (hereinafter called Prudential).

WITNESSETH, THAT:

WHEREAS, Prudential heretofore issued to the Policyholder its Group Policies Nos. GO-14500 (under date of November 1, 1958), GC-14500 (under date of July 1, 1962), GS-14500 (under date of June 1, 1963), GW-14500 (under date of April 1, 1966) and GZ-14500 (under date of May 16, 1964) providing, among other coverages, Medical Expense Insurance Coverages for certain employes of the Policyholder and their dependents; and

WHEREAS, said Medical Expense Insurance Coverages as provided under said Group Policies are to be terminated with respect to certain classes of said employes and their dependents, at the expiration of September 30, 1972; and

WHEREAS, the Policyholder wishes an immediate financial settlement under said terminating Medical Expense Insurance Coverages; and

WHEREAS, final determination of such immediate financial settlement cannot be made at this time because Prudential's accrued liability for payment of claims under said terminating Medical Expense Insurance Coverages extends beyond the aforesaid date of termination;

NOW, THEREFORE, for and in consideration of the premises and the mutual agreements of the parties hereto expressed, it is mutually stipulated, covenanted and agreed as follows:

(1) The Policyholder hereby accepts the liability for all payments to be made under said terminating Medi-

cal Expense Insurance Coverages with respect to claims submitted thereunder on and after October 1, 1972 and, subject to the further provisions hereof, agrees to make such payments upon receipt of satisfactory notice and proof.

(2) Notwithstanding (1) above, on or after October 1, 1972 Prudential may handle any claim under said terminating Medical Insurance Coverages in such manner as it shall deem appropriate, whether or not, with respect to such claim, any demand has been made of the Policyholder or any payment has been made by the Policyholder. In such an event, Prudential will give notice to the Policyholder. Upon notice from Prudential to the Policyholder of its intention to handle any such claim, the Policyholder shall transmit to Prudential all information and forms pertaining to such claim. Prudential shall notify the Policyholder of the amount of any payments made by it pursuant to the provisions hereof and upon receipt of such notice the Policyholder shall reimburse Prudential for the amount so paid plus the amount of any expenses incurred by Prudential in connection with any payments so made.

(3) Prudential does hereby agree to pay to the Policyholder, or any designee indicated in writing by the Policyholder, an amount of money equal to the amount of the Unrevealed Claim Charges established by Prudential for said terminating Medical Expense Insurance Coverages as of the expiration of September 30, 1972, reduced by the amount of all the bank drafts on Prudential which are issued prior to October 1, 1972, in payment of claims under said terminating Medical Expense Insurance Coverages, and clear the Prudential accounting system after September 30, 1972. The amount of said bank drafts is part of the said Unrevealed Claim Charges.

Since the exact amount of the reduced said Charges will not be ascertained until Prudential completes the annual fiscal accounting and dividend determination for all of the Policyholder's Group Insurance Coverages under Group Policies Nos. GO-14500, GC-14500, GS-14500, GW-14500, and GZ-14500 for the policy period ending June 30, 1973, a preliminary financial settlement will be made in the amount of $1,220,000 as soon as reasonably possible after October 1, 1972. The final settlement will be made as soon after June 30, 1973, as the annual fiscal accounting and dividend determination for the policy period ending June 30, 1973 is completed.

(4) The Policyholder for itself, its successors and assigns, hereby agrees with Prudential, its successors and assigns, to assume liability either directly in the manner set forth under (1) above or indirectly in the manner set forth under (2) above, and does hereby assume full liability for expenses, actions, legal fees and costs in connection with actions and demands of anyone in connection with any claim under said terminating Medical Expense Insurance Coverages submitted either to the Policyholder or Prudential on or after October 1, 1972.

IN WITNESS WHEREOF the parties have hereunto set their hands and seals this ____ day of ____ in the year 1972.

GENERAL DYNAMICS CORPORATION

Attest:
[SIGNATURE]

by [SIGNATURE]

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Attest:
[SIGNATURE]

by [SIGNATURE]
Assistant Secretary

PLAINTIFFS' EXHIBIT 2

AGREEMENT

This Agreement entered into by and between THE GENERAL DYNAMICS CORPORATION (hereinafter called the Policyholder) and THE PRUDENTIAL INSURANCE COMPANY OF AMERICA (hereinafter called Prudential).

WITNESSETH, THAT:

WHEREAS, Prudential heretofore issued to the Policyholder its Group Policies Nos. GO-14500 (under date of November 1, 1958), GC-14500 (under date of July 1, 1962) providing, among other coverages, Medical Expense Insurance Coverages for certain employes of the Policyholder and their dependents; and

WHEREAS, said Medical Expense Insurance Coverages as provided under said Group Policies are to be terminated with respect to certain classes of said employes and their dependents, at the expiration of November 30, 1972; and

WHEREAS, the Policyholder wishes an immediate financial settlement under said terminating Medical Expense Insurance Coverages; and

WHEREAS, final determination of such immediate financial settlement cannot be made at this time because Prudential's accrued liability for payment of claims under said terminating Medical Expense Insurance Coverages extends beyond the aforesaid date of termination;

NOW, THEREFORE, for and in consideration of the premises and the mutual agreements of the parties hereto expressed, it is mutually stipulated, covenanted and agreed as follows:

(1) The Policyholder hereby accepts the liability for all payments to be made under said terminating Medi-

cal Expense Insurance Coverages with respect to claims submitted thereunder on and after December 1, 1972 and, subject to the further provisions hereof, agrees to make such payments upon receipt of satisfactory notice and proof.

(2) Notwithstanding (1) above, on or after December 1, 1972 Prudential may handle any claim under said terminating Medical Insurance Coverages in such manner as it shall deem appropriate, whether or not, with respect to such claim, any demand has been made of the Policyholder or any payment has been made by the Policyholder. In such an event, Prudential will give notice to the Policyholder. Upon notice from Prudential to the Policyholder of its intention to handle any such claim, the Policyholder shall transmit to Prudential all information and forms pertaining to such claim. Prudential shall notify the Policyholder of the amount of any payments made by it pursuant to the provisions hereof and upon receipt of such notice the Policyholder shall reimburse Prudential for the amount so paid plus the amount of any expenses incurred by Prudential in connection with any payments so made.

(3) Prudential does hereby agree to pay to the Policyholder, or any designee indicated in writing by the Policyholder, an amount of money equal to the amount of the Unrevealed Claim Charges established by Prudential for said terminating Medical Expense Insurance Coverages as of the expiration of November 30, 1972, reduced by the amount of all the bank drafts on Prudential which are issued prior to December 1, 1972, in payment of claims under said terminating Medical Expense Insurance Coverages, and clear the Prudential accounting system after November 30, 1972. The amount of said bank drafts is part of the said Unrevealed

Claim Charges. Since the exact amount of the reduced said Charges will not be ascertained until Prudential completes the annual fiscal accounting and dividend determination for all of the Policyholder's Group Insurance Coverages under Group Policies Nos. GO-14500 and GC-14500 for the policy period ending June 30, 1973, a preliminary financial settlement will be made in the amount of $1,180,000 as soon as reasonably possible after December 1, 1972. The final settlement will be made as soon after June 30, 1973, as the annual fiscal accounting and dividend determination for the policy period ending June 30, 1973 is completed.

(4) The Policyholder for itself, its successors and assigns, hereby agrees with Prudential, its successors and assigns, to assume liability either directly in the manner set forth under (1) above or indirectly in the manner set forth under (2) above, and does hereby assume full liability for expenses, actions, legal fees and costs in connection with actions and demands of anyone in connection with any claim under said terminating Medical Expense Insurance Coverages submitted either to the Policyholder or Prudential on or after December 1, 1972.

IN WITNESS WHEREOF the parties have hereunto set their hands and seals this first day of December in the year 1972.

Attest:

[SIGNATURE]

Assistant Secretary

GENERAL DYNAMICS CORPORATION

by [SIGNATURE]

Executive Vice President-Finance

Attest:

[SIGNATURE]

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

by [SIGNATURE]

Assistant Secretary

PLAINTIFFS' EXHIBIT 3

AETNA LIFE & CASUALTY
151 Farmington Avenue
Hartford, Connecticut 06115

James D. Holland
Secretary
Group Division

September 20, 1972

General Dynamics Corporation
Pierre Laclede Center
St. Louis, Missouri 63105

Gentlemen:

RESERVE REFUND AGREEMENT

In connection with the adoption of the Administrative Services Contract effective October 1, 1972 the agreement described below is being entered into by Aetna Life Insurance Company and General Dynamics Corporation. This agreement applies only to the reserves held for that portion of your plan of medical and dental benefits which will no longer be insured by Aetna after September 30, 1972, and will be subject to an Administrative Services Contract thereafter. The purpose of this agreement is to allow certain reserves to be refunded to General Dynamics Corporation and to allow Aetna to use service contract drafts for all benefit payment drafts issued on and after the effective date of the Administrative Services Contract in connection with the benefits concerned, thereby facilitating the transition from an insured plan to an uninsured plan of the portion of your group insurance program to which this agreement applies.

Under this agreement, Aetna Life Insurance Company agrees that it will refund to General Dynamics Corporation reserves under the coverages affected by the Administrative Services Contract, which reserves it would other-

wise hold as of October 1, 1972 for the purpose of subsequently discharging the then outstanding liability under these coverages.

The amount of the reserves to be refunded to General Dynamics Corporation will be determined on the basis of the claim reserves shown on our experience accounting statements for such benefits as of October 1, 1972 minus the sum of (i) all drafts which have already been issued but which have not yet cleared our bank for payment as of such date, and (ii) the amount of any experience deficit indicated on such accounting statements for the experience rating group involved. The payout of reserves so determined to be available for refund will be accomplished in such monthly amounts as mutually agreed upon. It is expected that the reserve refund will occur within the first four months following October 1, 1972.

Aetna will continue to be liable for and pay the drafts indicated in item (i) of the preceding paragraph which are presented to its bank for payment during the period October 1, 1972–September 30, 1973.

In return for the refund of the reserves described above, General Dynamics Corporation agrees to allow all drafts issued by Aetna on and after October 1, 1972 with respect to claims payable under the coverages affected by the Administrative Services Contract to be charged against the funds of General Dynamics Corporation. General Dynamics Corporation also agrees to make sufficient funds available for this purpose irrespective of the in-force status of the service contract at that time. This will then allow Aetna to use service contract drafts, which would in time be charged against your funds, for all claim drafts issued on and after October 1, 1972.

As soon as practicable after October 1, 1973 a final accounting will be prepared with respect to the amounts described in the second prior and third prior paragraphs of this agreement which are known at that time. Based on

this accounting, a settlement will be made for any adjustment necessary to make up the difference between the estimated figures on which the reserve refund payments may have been made and the corresponding applicable actual figures. If this accounting indicates that the amount of the settlement is due your Company, such amount will accompany the accounting. If the amount of the settlement is due Aetna, such amount will be payable by your Company to Aetna within 30 days following the date the accounting is mailed to your company.

Since the monthly reserve refund payments by Aetna and the settlement referred to in the previous paragraphs will result in the complete refund of all available reserve funds for the coverages affected, General Dynamics Corporation agrees to reimburse Aetna for the amount of any drafts issued prior to October 1, 1972 which clear our bank for payment on and after the accounting date used in the previous paragraph, irrespective of the in-force status of the Administrative Services Contract at that time. Such reimbursement will be due within 30 days following the presentation by Aetna to your Company of an accounting for such amount. We expect to submit any such accountings at subsequent renewals of the service contract arrangement and periodically thereafter if the service contract has been terminated.

Very truly yours,

/s/ JAMES D. HOLLAND

James D. Holland
Secretary

Accepted by GENERAL
DYNAMICS CORPORATION

[SIGNATURE]

Vice President,
Industrial Relations

26 September 1972

PLAINTIFFS' EXHIBIT 9

PART II
YOUR BASIC MEDICAL EXPENSE BENEFITS AND MAJOR MEDICAL EXPENSE BENEFITS

* * * * *

HOSPITAL EXPENSE BENEFITS

This coverage provides benefits for room and board and other services in connection with a hospital confinement for which a room and board charge is made and which is ordered by a physician as the result of a non-occupational injury or sickness, other than pregnancy. If the initial hospital visit is for emergency care within 72 hours after an accident or the onset of serious and sudden illness, or is for surgery, the requirement that a room and board charge be made shall not apply in connection with any charge included as part of the "Other Services" section.

Room and Board Benefits—The benefit payable is equal to the charges made by a hospital for room and board and all regular daily services and supplies. The daily benefit will not exceed the Maximum Daily Room and Board Benefit shown in the Plan Summary.* The maximum benefit per confinement will not exceed the Total Room and Board Benefit also shown in the Plan Summary.

Other Services—This benefit pays the cost of hospital services and supplies, such as, operating room, X-rays, medicines, etc. administration of anaesthetics by a physician and use of ambulance service for travel to and from the hospital. The services and supplies must be in connection with the hospital confinement. The benefit will not exceed the Maximum Other Services Benefit shown in the Plan Summary.

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* Wherever "Plan Summary" appears in this Part II, refer to Plan Summary (Part II).

Full benefits will be available for each confinement due to a different cause. If more than one confinement is needed for the same cause, full benefits will be available for each, provided the confinements are separated by complete recovery, or, in the case of your own confinement, your return to active work.

SURGICAL EXPENSE BENEFITS

This coverage provides benefits for the fee of a physician for performing an operation needed because of a non-occupational injury or sickness, other than pregnancy. The operation may be performed in the physician's office, in a hospital or anywhere else.

This plan will pay the fee the physician charges, up to the amount listed for the operation in the Schedule of Surgical Procedures included in the Plan Summary. The Maximum Surgical Expense Benefit for all operations due to the same causes and not separated by complete recovery, or, in the case of operations on you, not separated by your return to active work, is shown in the Plan Summary.

MATERNITY EXPENSE BENEFITS

Hospital Expenses

The plan will pay benefits, up to the Maternity Hospital Expense Maximums shown in the Plan Summary, for the following expenses incurred in connection with a hospital confinement due to pregnancy of a female Employe or of an Employe's wife. The confinement must be ordered by a physician and begin while she is covered or during the nine months following the date the coverage ended.

(1) The hospital's charge for room and board and all other services for medical care and treatment, excluding professional services;

(2) Physician's fees for administering anaesthetics in the hospital;

(3) Charges for ambulance service for travel to and from the hospital.

Obstetrical Expenses

The plan will also pay the fee of a physician for an obstetrical procedure, up to the Maternity Surgical Expense Maximum shown in the Plan Summary. The procedure must be performed while Maternity Hospital Benefits apply.

HOSPITAL MEDICAL EXPENSE BENEFITS

This coverage provides benefits for visits by a physician during a confinement in a hospital resulting in a room and board charge. The confinement may be due to any non-occupational injury or sickness other than pregnancy.

For Confinement During Which No Operation is Performed—The plan will pay the physician's fee, up to the Hospital Medical Daily Limit shown in the Plan Summary.

For Confinement During Which an Operation is Performed—The plan will pay the physician's fee for visits made before the date of the operation, up to the Hospital Medical Daily Limit shown in the Plan Summary.

The Maximum Hospital Medical Benefit for each confinement is shown in the Plan Summary.

Full benefits will be available for each confinement due to a different cause. If more than one confinement is needed for the same cause, full benefits will be available for each, provided the confinements are separated by complete recovery, or, in the case of your own confinement, by your return to active work.

DIAGNOSTIC X-RAY AND LABORATORY EXPENSE BENEFITS

(Effective July 1, 1973)

This coverage provides benefits for diagnostic X-ray and laboratory examinations ordered by a physician and

made necessary by a non-occupational injury or sickness, other than pregnancy.

The plan will pay the fee charged, at the Rate of Payment shown in the Plan Summary. The total payment will not exceed the Maximum Diagnostic X-Ray and Laboratory Expense Benefit shown in the Plan Summary.

These benefits do not apply to:

(1) expenses paid or payable under other parts of the plan other than Major Medical Expense Benefits:
(2) expenses in connection with dental work or treatment;
(3) routine "check-up" examinations;
(4) examinations made during a hospital confinement for emergency care after an accident, for surgery, or for which room and board charges are made.

EMERGENCY CARE EXPENSE BENEFITS

This coverage provides benefits for a doctor's charges incurred for the initial visit for emergency care within 72 hours of an accident or the onset of serious and sudden illness. Only non-occupational accidents and illnesses are covered. The visit may take place in a hospital's outpatient department or in a doctor's office.

These benefits do not apply to:

(1) Services if charged for in a hospital's charges for emergency care;
(2) An expense if any benefit is payable with respect to that expense under other parts of the plan other than Major Medical Expense Benefits.

RADIOTHERAPY EXPENSE BENEFITS

Benefits are provided for radiotherapy treatments, including professional services and materials and facilities used, toward the expenses incurred which are not paid under other parts of the Plan. For benefits to be payable,

the therapy must be ordered by a physician and required for sickness or accidental bodily injury, other than for diagnostic purposes.

The Plan will pay the amount charged up to the amount listed for the procedure in the Schedule of Radiotherapy shown in the Plan Summary.

The total payment will not exceed the Maximum Radiotherapy Benefit shown in the Plan Summary.

When two or more treatments are administered on the same day, the amount payable for all such treatments will not exceed the amount for the treatment with the highest limit.

MAJOR MEDICAL EXPENSE BENEFITS

This coverage provides benefits for the eligible expenses described below when incurred for the care and treatment of a non-occupational sickness or injury. Payment of benefits for you or a covered dependent will begin when the deductible shown in the Plan Summary has been satisfied.* Benefits will be paid at the rate shown in the Plan Summary for all eligible expenses the individual incurs during the rest of the year (except as provided below in connection with mental illness or functional nervous disorder).

* But the deductible does not apply to eligible expenses for the following services (under the conditions explained below):

(1) Hospital room and board;
(2) Other hospital services;
(3) Ambulance service;
(4) Anaesthetics and their administration.

Conditions in which the deductible does not apply—(a) Hospital confinement for which room and board charges are made, or (b) in connection with in-hospital surgery, or (c) the initial hospital visit for emergency treatment within 72 hours of an accident or the onset of sudden and serious illness.

When the deductible does not apply, benefits will be paid at the rate shown in the Plan Summary; the remainder of such expenses may not be applied to the deductible.

ELIGIBLE EXPENSES

The eligible expenses are the following services and supplies:

Hospital Room and Board—Charges for room and board. (For private accommodations, the eligible expenses are subject to the limit in the Plan Summary. Intensive care units are not considered private accommodations.)

Other Hospital Services—Charges for services such as operating room, drugs, X-rays, laboratory tests, administration of anaesthetics, etc.

Ambulance Service for travel to and from the hospital.

Expenses In or Out of the Hospital

Doctors services—Surgery, home, office and hospital visits, and other medical care and treatment.

Nursing care—Private duty nursing by a registered graduate nurse.

Speech therapy—By a qualified speech therapist to restore speech loss, or correct an impairment, due to (a) a congenital defect for which corrective surgery has been performed, or (b) an accident or sickness except a functional nervous disorder.

Physiotherapy—Treatment by a physiotherapist.

Dental treatment due to accident—As an additional feature, the following dental services received within 12 months of an accident are eligible: Treatment by a physician, dentist, or dental surgeon of injuries to natural teeth including replacement of such teeth, treatment of a fractured jaw, and related X-rays.

Expenses Outside the Hospital

Anaesthetics and their administration.

X-ray and laboratory examinations.

X-ray and radium treatments and treatments with other radioactive substances.

Medical supplies—Drugs and medicines dispensed by a licensed pharmacist; blood and blood plasma; artificial limbs, eyes and larynx; electronic heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches; rental of wheel chair, hospital bed, or iron lung; oxygen and rental of equipment for its administration.

DEDUCTIBLE CARRY-OVER PROVISION

A new deductible will apply each calendar year. However, expenses incurred in the last three months of a year which are applied against that year's deductible can also be applied toward the deductible for the next year and thus reduce or eliminate that year's deductible.

MENTAL ILLNESS OR FUNCTIONAL NERVOUS DISORDER

Major Medical Expense benefits for all eligible expenses incurred during a hospital stay resulting in a room and board charge or for charges in connection with administration of convulsive therapy will be determined in the regular way. Otherwise, the following will apply:

After satisfaction of the usual deductible, benefits for eligible expenses will be payable at the rate shown in the Plan Summary with respect to such expenses. For professional psychiatric services, not more than the number of visits shown in the Plan Summary, nor more than the dollar limit per visit shown there will be counted.

THE FOLLOWING EXPENSES ARE NOT ELIGIBLE

(1) Expenses for eye refractions; fitting of glasses or hearing aids; expenses for cosmetic surgery unless required as a result of an accident sustained while covered.

2. Expenses for nursing care or physiotherapy or speech therapy rendered by you or your spouse, or a child, brother, sister, or parent of yourself or spouse.
3. Expenses for services, treatments or supplies to the extent that benefits are provided for such expenses under any other coverage of this Plan.
4. Expenses for pregnancy, except that if a pregnancy commences while a female employe or employe's wife is covered the following expenses will be covered:
   (a) Expenses, while hospitalized, solely for pernicious vomiting or toxemia with convulsions;
   (b) The following surgery and related hospital and other expenses after surgery: Caesarean after 6 months; intra-abdominal surgery after pregnancy terminates; operation for extra-uterine pregnancy.
5. Expenses resulting from an act of war, declared or undeclared (including resistance to armed aggression) occurring while covered.

Pre-existing Conditions

If you or your family members have undergone treatment for any condition within 90 days before the effective date of your insurance, you will be eligible for benefits for that condition at the end of a 90 day period which ends while you or your dependent is covered, and during which no medical expenses or treatment is incurred for that condition.

In any event, an employee will become eligible for benefits for pre-existing conditions after completing a 6 month period of continuous employment on a full-time basis while covered for major medical benefits.

* * * * *

Also see "General Exclusions – Medical Expenses" on a later page.

MAXIMUM PAYMENT

The Plan will pay up to the Maximum Benefit shown in the Plan Summary for you and for each of your covered dependents for all causes combined for a lifetime.

Automatic Restoration—On the first of each year, each covered person who then has benefits charged to his overall maximum will automatically have an amount restored for future use. The amount to be restored each year will be $1,000, or the amount needed to bring the maximum back to the full amount, whichever is less.

Request for Restoration—If a person who has received at least $1,000 in major medical benefits recovers and furnishes satisfactory evidence of good health, his overall maximum will be restored in full.

GENERAL EXCLUSIONS—MEDICAL BENEFITS

The medical expense coverages do not cover:

Charges for a service or supply (a) furnished by or for any government, unless the government is other than the U.S. Government and payment is legally required, or (b) to the extent any benefit is provided by any law or governmental program under which a person is or could be covered.

Anything not ordered by a physician or not reasonably necessary for medical care of sickness or injury; check-up examinations and tests not reasonably necessary to medical treatment.

Any charge for a service or supply to the extent to which it exceeds the smaller of (a) the usual charge by the provider when there is no insurance and (b) the general level of charges for a comparable service or supply made by other providers within the same county (or larger area if necessary to get a representative cross-section).

Charges for physicians' services or X-ray examinations for mouth conditions due to periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue, except for treatment or removal of malignant tumors. (This exclusion does not apply to certain dental treatment as described under Major Medical Expense Benefits.)

Physicians' services for (a) weak, strained, flat, unstable or imbalanced feet, or metatarsalgia or bunions, except open cutting operations, or (b) corns, calluses or toenails, except removing nail roots and care prescribed by an M.D. or D.O. treating a metabolic or peripheral-vascular disease.

Charges for eye refractions or other examinations to determine the need for, or the adjustment of, eye glasses.

Expenses for services or supplies to the extent the person receives payment or reimbursement for such expenses as a result of legal action or settlement.

MISCELLANEOUS MEDICAL EXPENSE PROVISIONS

Coordination With Other Plans

The purpose of our health plan is to help meet the covered expenses you and your dependents actually incur. Sometimes, though, because individuals have medical care protection under more than one plan, the total benefits may exceed the actual expenses. Such excess coverage tends to increase unnecessarily the cost of the plan. Therefore, your plan contains a provision coordinating it with any coverage the patient may have under other plans. The provision is designed to guard against excess coverage and help preserve the future benefits for everyone.

When a request for Benefit is made, the coordination provision governs whether our plan will pay its regular amount or whether this will be adjusted so that the bene-

fits available from all plans will not exceed 100% of the allowable expenses. An "allowable expense" is any necessary, reasonable and customary expense included in any of the plans.

If, because of the coordination provision, our plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase the patient's later benefit payments under our plan in the same calendar year, to the extent there are allowable expenses that would otherwise not be fully paid by our plan and the other plans. Thus the later benefit may be larger under our plan than would normally be allowed.

"Other plans" refer to these types of medical or dental care benefits: (a) coverage under a governmental program or required or provided by statute, and (b) group insurance or other coverage for a group of individuals, including prepayment coverage, group or individual practice coverage; (c) coverage for students sponsored by or provided through an educational institution. "Other plans" do not include benefits payable under individual policies of Accident and Health Insurance which you may have purchased on your own.

PAYMENT OF BENEFITS

It will be necessary for you to submit satisfactory written proof of each charge for which benefits are being requested, and each charge used to satisfy the deductible. You may also be required to furnish written proof that such charges were for services, treatments and supplies ordered by a physician. Therefore, be sure to keep an accurate record of each covered individual's medical expenses, and retain all bills and receipts.

EXTENSION OF MEDICAL EXPENSE BENEFITS

If the Hospital Expense, Surgical Expense, Hospital Medical Expense, Diagnostic X-Ray and Laboratory Ex-

pense Benefits and Radiotherapy Expense coverages terminate, the benefits under these coverages will be extended for three months to cover a confinement, visits by a physician during confinement, treatments, examinations or an operation resulting from a continuous total disability that began while the coverages were in force and which would have been covered had the coverages continued.

If a covered individual is totally disabled and under the care of a physician for reasons other than pregnancy when the Major Medical Expense coverage terminates, coverage will be extended during such total disability but not beyond the end of the calendar year following that in which the coverage terminates. This extension of benefits will apply only to expenses due to the sickness or injury which caused the total disability of the person.

For a pregnancy of a female Employe or Employe's wife which exists when employment terminates and which would hvae been eligible for maternity benefits had employment not been terminated, coverage will be extended for the duration of the pregnancy. If the individual is confined in a hospital at the termination of the pregnancy, the coverage will be further extended while she remains continuously confined due to the pregnancy.

TERMINATION OF PART II COVERAGE

When your employment terminates or you cease to be a member of a class eligible for coverage under this Plan your coverage under this Plan will cease. If you are required to make contributions for this coverage and if you fail to make the contributions, coverage will cease, unless terminated sooner for other reasons, at the end of the period for which contribution has been made. Satisfactory evidence of good health must be furnished before coverage can again be obtained.

Your coverage under the Plan will terminate upon discontinuance of the Plan.

Ceasing active work will be considered to be immediate termination of employment, except that if you are absent from active work because of sickness, injury or leave of absence, employment may be deemed to continue for the purposes of some of the medical expense coverage, subject to certain time limits. If you cease active work for any reason, you should find out immediately from your Employer what coverage, if any, can be continued in force so that you will be able to exercise any rights you may have under the Plan.

Dependents Coverage Only:

A dependent's coverage will terminate if dependents coverage under the Plan terminates, or if your own coverage terminates, or if he ceases to be an eligible dependent.

DEFINITIONS

Definition of Hospital

For the purpose of this Plan, a "hospital" is a legally operated institution which provides complete in-patient services for a fee, including surgical facilities, under supervision of a staff of physicians. The term does not include an institution, or part of one, which is used principally as a rest or nursing facility, or facility for the aged or for the care and treatment of drug addicts or alcholics.

Definition of Physician

For the purpose of this Plan, "physician" means a physician or surgeon who is licensed to practice medicine and perform surgery. The term also includes a licensed dentist, podiatrist or optometrist practicing in his own field.

Definition of Non-occupational Sickness or Injury

For the purpose of this Plan, "non-occupational sickness" means sickness not covered by any workmen's compensation law, occupational disease law or similar legisla-

tion: "non-occupational injury" means injury not arising out of, or in the course of, any employment for wage or profit.

PLAN SUMMARY

(Part II)

PLAN OF MEDICAL EXPENSE BENEFITS PROVIDED BY GENERAL DYNAMICS CORPORATION

Eligibility Provisions

Effective Date of Plan: December 1, 1972

Eligible Class of Employes: All Employes of the Employer's Electric Boat Division who are represented by the Patternmakers of New London, Connecticut, affiliated with the AFL-CIO.

Waiting Period: You will not become covered for these benefits until you have completed 30 days of continuous service with the Employer.

Becoming Covered: In order to obtain this coverage, it is necessary to fill in the enrollment form.

Should you not be working full-time on the day you would ordinarily become covered the coverage for yourself and your eligible dependents will be delayed until you return to full-time work.

Your coverage for a dependent will be delayed if on the date it would become effective the dependent is confined for medical care or treatment in an institution or at home. The delay will end and coverage for that dependent begin upon final medical release of the dependent from such confinement.

After your coverage becomes effective, it is necessary to notify your Employer of any change in the number of your dependents which will result in a change from one to the other of the following classifications:

(1) Employe without dependents;

(2) Employee with one dependent;

(3) Employe with more than one dependent.

If you wish to include a new dependent, you must make a separate request to your Employer.

Eligible Dependents: The dependents who are eligible for medical benefits are your spouse (unless legally separated) and unmarried children less than 19 years old.

Unmarried children who are 19 but less than 23 years old are also eligible provided they depend wholly upon you for support and are full-time students in an educational institution.

Children are eligible from birth except for hospital room and board charges during the first seven days.

Stepchildren, foster children and legally adopted children are included the same as your own children, provided they depend upon you for support, are living in the same household, and are reported for the coverage.

No one will be eligible as a dependent while covered as an employe or while in military service.

A child who is physically or mentally incapable of self-support upon attaining age 19 may be continued under the medical benefits while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. This privilege also will apply to a child who has remained in the plan beyond his nineteenth birthday if, while still covered by the plan, he later ceases to be a qualified dependent and is physically or mentally incapable of self-support and is not married. To continue a child under this provision, proof of incapacity must be furnished within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

If you have met the requirements for covering your dependents shown above, an eligible dependent will become covered immediately.

Benefits For You And Your Dependents–

Hospital Expense:

Maximum Daily Room and Board Benefit:

Prior to July 1, 1973: $60.00;

On and after July 1, 1973 but prior to July 1, 1974; $65.00;

On and after July 1, 1974; $70.00.

Total Room and Board Benefit: The person's Maximum Daily Room and Board Benefit for each day of confinement, up to 365 days.

Maximum Other Services Benefit: $800.00.

Surgical Expense: The plan will pay the fee of a physician for a surgical procedure, up to the amount listed for the procedure in the surgical schedule included as part of this Summary. The Maximum Surgical Expense Benefits payable for all operations performed during any one period of disability is $1,300. (This maximum will be increased to $1,400 effective July 1, 1973 and to $1,500 effective July 1, 1974.)

Hospital and Surgical Maternity:

Maternity Hospital Expense Maximums:

Prior to July 1, 1973: $60.00;

On and after July 1, 1973 but prior to July 1, 1974; $65.00;

On and after July 1, 1974; $70.00.

Total Room and Board Benefit: The person's Maximum Daily Room and Board Benefit for each day of confinement, up to 365 days.

Maximum Other Services Benefit: $800.00.

Maternity Surgical Expense Maximums:

	Prior to 7-1-73	Effective 7-1-73
Delivery of child or children	$100.00	$150.00
Caesarean section, including delivery	200.00	300.00
Abdominal operation for extra uterine pregnancy	200.00	300.00
Miscarriage including dilation and curettage	50.00	75.00

These benefits will not apply to any pregnancy commencing before a female Employe or an Employe's wife is covered under the plan.

Hospital Medical Expense (Physicians' Visits While Hospital Confined):

Hospital Medical Daily Limit: $10.00 for the first day and $6.00 for each day thereafter.

Maximum Hospital Medical Benefit: The applicable daily benefit for the first 366 days of confinement.

Emergency Care Expense Benefit: See page 13 of Booklet.

Diagnostic X-Ray and Laboratory Expense: (Effective July 1, 1973).

Rate of Payment: 80%.

Maximum Diagnostic X-Ray and Laboratory Expense Benefit: $75.00 during any period of twelve consecutive months.

Radiotherapy Expense:

The plan will pay up to the amount listed for the radiotherapy treatment listed in the schedule of radiotherapy included as part of this Plan Summary.

Maximum Radiotherapy Benefit: $300 per calendar year.

Major Medical Expense Benefits:

Deductible: $100.00 of eligible expenses incurred by a covered person during a calendar year ($100 for a family).

Private Room Limit: The hospital's standard semi-private room daily rate. If the hospital does not have semi-private rooms, the limit is 80% of the daily charge for its lowest rate private room.

Rate of Payment: 80% of eligible expense incurred after satisfaction of the deductible. However the plan will pay only 50% with respect to charges for treatment of mental illness or functional nervous disorder, other than convulsive therapy, not involving a hospital stay resulting in a room and board charge.

For professional psychiatric services

Visit Limit – 50 per calendar year.

Dollar Limit – $20.00 per visit (maximum benefit – $10.00 per visit).

Maximum Benefit: $15,000 for all illnesses of a covered person during his lifetime.

Schedule of Surgical Procedures

(1) "Surgical procedure" means only cutting, suturing, electrocauterization, removal of stone or foreign body by endoscopic means, or injection of sclerosing solution.

(2) This Schedule includes all surgical procedures described in (1), other than any expressly not covered by this Schedule, or by the terms of the coverage to which it applies. A consistent scheduled limit, not to exceed $650*, will be determined for any included procedure not listed.

(3) A combination of surgical procedures is considered one procedure if a scheduled limit is shown for the combination.

(4) Two or more surgical procedures performed through the same abdominal incision will be considered as one operation (that one of such procedures for which the largest maximum payment is provided by this Schedule).

(5) If, at one session, more than one operation is performed in the same operative field or through one incision, the maximum benefit will be the amount for the operation having the highest limit. But if the operations are in different fields and require separate incisions, the maximum benefit will be the amount for the field with the highest limit plus 50% of the amount for each other field.

* This amount will be increased to $700 (effective July 1, 1973) and to $750 (effective July 1, 1974). Revised surgical schedules reflecting changes in Scheduled Limits

resulting from these increases will be issued in the future as supplemental pages to your Plan Summary.

	Scheduled Limit
CARDIOVASCULAR SYSTEM	
Pericardiectomy	$433.50
Thromboendarterectomy of abdominal aorta	650.00
Valvulotomy or commissurotomy	
Aortic, pulmonic or tricuspid	650.00
Mitral	520.00
Varicose veins	
Injection of sclerosing solution into vein(s) of leg	6.50
Cutting operation, with or without injection	
Ligation and division and complete stripping	
long or short saphenous veins, unilateral	130.00
long or short saphenous veins, bilateral	216.50
long and short saphenous veins, unilateral	173.50
long and short saphenous veins, bilateral	260.00
Ligation and division of short saphenous vein at saphenopopliteal junction	80.00
DIGESTIVE SYSTEM	
Adenoidectomy	43.50
Anal papillectomy, one or more	21.75
Appendectomy	200.00
Appendicial abscess, transabdominal incision and drainage	200.00
Aspiration biopsy of liver	21.75

	Scheduled Limit
Cholecystectomy	260.00
With open exploration of common duct	303.50
Cholecystotomy	216.75
Colectomy	
Partial resection of large intestine in two stages including first stage colostomy or cecostomy	$433.50
Enterectomy	
Resection of small intestine with anastomosis or enterostomy	303.50
Excision of submaxillary gland, tumor, or both	173.50
Fissurectomy with or without sphincterotomy	86.75
Fistulectomy or fistulotomy, subcutaneous	50.00
Fistulectomy or fistulotomy, submuscular	173.50
Gastrectomy with or without vagotomy	
Subtotal or hemi-gastrectomy	346.75
Total gastrectomy	433.50
Gastroduodenostomy or gastrojejunostomy	260.00
Gastroscopy or esophagoscopy	
Diagnostic, with or without biopsy	70.00
Gastrotomy or gastrorrhaphy	216.75
Hemorrhoids	
Excision of external hemorrhoidal tabs	21.75
External hemorrhoidectomy, complete	86.75
External and internal, or internal hemorrhoidectomy	130.00
Hemorrhoidectomy and submuscular fistulotomy or fistulectomy	173.50
Hemorrhoidectomy and fissurectomy	130.00
Incision of external thrombotic hemorrhoid	20.00
Injection of sclerosing solution	8.75

	Scheduled Limit
Hernioplasty, herniorrhaphy, or herniotomy	
Epigastric, femoral, inguinal	161.75
Inguinal with orchiectomy or excision of hydrocele	173.50
Umbilical, under age 5 years	130.00
Umbilical, age 5 year or over	151.75
Incision and drainage of ischiorectal abscess	50.00
Laparotomy, exploratory	200.00
Marsupialization of cyst or abscess of liver	303.50
Pancreatectomy, total	606.75
Proctectomy complete, combined abdominoperineal, one or two stages	433.50
Proctosigmoidoscopy	
Initial	20.00
Subsequent	20.00
With biopsy	21.75
With removal of polyp	50.00
With removal of polyps	50.00
Tonsillectomy, with or without adenoidectomy	
Under age 18 years	$ 65.00
Age 18 years or over	86.75
EAR AND EYE	
Cataract	
Discission: needling of lens	
Initial	100.00
Subsequent	100.00
Extraction of lens, intracapsular, extracapsular, or linear	346.75
Enucleation eyeball	173.50
Excision of pterygium	108.50
Mastoidectomy, simple	216.75
Myringotomy, tympanotomy, plicotomy	20.00

	Scheduled Limit
Reattachment of retina	
Electrocoagulation, scleral resection, buckling or partial tubing	433.50
Light coagulation of retinal breaks	173.50
Removal of foreign body embedded in conjunctiva	10.00
Stapes mobilization	303.50
ENDOCRINE, HEMIC, LYMPHATIC SYSTEMS	
Biopsy or excision of lymph node	
Anterior scalene	65.00
Other	21.75
Excision of cyst or adenoma of thyroid	200.00
Thyroidectomy	
For malignancy with radical neck dissection	433.50
Total or complete	303.50
Total thyroid lobectomy	216.75
FEMALE GENITAL SYSTEM	
Amputation of cervix	100.00
Biopsy of cervix or endometrium	20.00
Dilation and curettage of uterus under general anesthesia	65.00
With conization	100.00
Excision or cautery destruction of Bartholin's gland or cyst	65.00
Hysterectomy	
Radical for cancer, including regional lymph nodes	433.50
Subtotal or supracervical	238.50
Total (corpus and cervix)	300.00
Repair of cystocele with or without urethrocele	151.75
Repair of cystocele, rectocele and perineoplasty, with or without repair of urethrocele	216.75

	Scheduled Limit
Repair of rectocele	130.00
Salpingectomy, oophorectomy or salpingo-oophorectomy, complete or partial, unilateral, or bilateral	200.00
INTEGUMENTARY SYSTEM	
Breast	
Mastotomy with exploration or drainage of abscess, deep	50.00
Partial mastectomy, or excision of cyst or tumor	
Unilateral	65.00
Bilateral	108.50
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes	303.50
Simple mastectomy, complete	200.00
Excision of benign lesion of skin, subcutaneous tissue or mucous membrane, lesion diameter:	
¼ inch or less	20.00
over ¼ but not over ½ inch	21.75

Excision of malignant lesion of skin or mucous membrane of:	Lesion diameter: ¼ inch or less	Lesion diameter: over ¼ inch not over ½ inch
Trunk, arms or legs	$50.00	$50.00
Face, scalp, ears, neck, hands, feet, genitalia	50.00	65.00
Eyelids, lips, mucous membrane	65.00	86.75

Incision and drainage of sebaceous cysts, furuncle, carbuncle or any other subcutaneous abscess	10.00

	Scheduled Limit
Suturing of wounds (all wounds combined)	
2½ inches or less	17.50
over 2½ but not over 5 inches	28.50
MALE GENITAL SYSTEM	
Circumcision	
Age less than 15 days	13.00
Age 15 days or older	43.50
Epididymectomy or excision of hydrocele or varicocele	130.00
Orchiectomy, unilateral	86.75
Orchiectomy, bilateral	140.00
Prostatectomy (one or two stages, complete procedure)	346.75
MUSCULOSKELETAL SYSTEM	
AMPUTATIONS, complete procedure	
Ankle, with skinplasty and resection of nerves	216.75
Arm through humerus or through radius and ulna	173.50
Digit, with or without split or Wolff graft, skinplasty, tenodesis, or definitive resection volar digital nerves	
Finger or thumb	65.00
Toe	43.50
Disarticulation of hip	346.75
Disarticulation of knee	200.00
Disarticulation of shoulder	325.00
Foot, midtarsal or transmetatarsal	151.75
Hand, midcarpal or transmetacarpal	173.50
Leg through tibia and fibula	216.75
Thigh through femur, including supracondylar	260.00
BONES	
Excision of bone cyst or chondroma:	
Humerus, radius, ulna, pelvis, femur, tibia, or fibula	216.75

	Scheduled Limit
Carpal or tarsal bones	108.50
Fractures, closed reduction of	
Ankle	
bimalleolar (including Pott's), simple	108.50
trimalleolar, simple	130.00
Astragalus or os calcis, simple	86.75
Carpal, one or more, simple	43.50
Clavicle, simple	65.00
Femur	
distal end, condyle(s), or both, simple	151.75
intertrochanteric, simple with fixation or traction	195.00
neck, simple, with fixation or traction	216.75
shaft, including supracondylar, simple	173.50
Fibula	
distal end, malleolus, or both	100.00
shaft, simple	100.00
with tibia, shafts, simple	130.00
Humerus	
medial or lateral condyle	100.00
shaft, simple	108.50
surgical neck, simple	130.00
Malar, simple or compound	50.00
Maxilla or mandible, simple or compound, with wiring of teeth	130.00
Metacarpal, simple or compound	
one	43.50
more than one	54.25
Metatarsal, simple	43.50
Nasal, simple or compound	21.75
Patella, simple	100.00
Pelvis, simple	100.00
Phalanx or phalanges, simple, one finger, thumb, or toe	21.75

	Scheduled Limit
Radius	
head or distal end, simple	65.00
shaft, with or without ulna, simple	86.75
Ribs, one or more, simple	28.25
Scapula or sternum, simple	52.00
Tarsal (other than astragalus or os calcis) one or more, simple	43.50
Tibia	
distal end, malleolus, simple	100.00
shaft, or proximal end, with or without condyle(s), or intercondylar spines, simple	108.50
with fibula, shafts, simple	130.00
Ulna, shaft, with or without radius, simple	86.75
Vertebral body (other than sacrum), one or more	130.00
Vertebral processes, one or more	34.75
Spinal fusion, two or more segments	411.75
JOINTS	
Arthrectomy	
Excision of intervertebral disc, with spinal fusion	520.00
Excision of semilunar cartilage, knee joint	216.75
Temporomandibular joint	325.00
Arthrotomy or capsulotomy with exploration, drainage, or removal of loose body	
Finger, thumb, or great toe	65.00
Hip	303.50
Shoulder, elbow, knee or ankle	216.75
Toe, other than great toe	43.50
Dislocations, closed reduction of	
Ankle or tarsal, simple	50.00
Clavicle, simple, with general anesthesia	43.50

	Scheduled Limit
Wrist, elbow or shoulder (humerus), simple	50.00
Finger, one or more joints, simple	20.00
Hip (femur) or knee (femoral-tibial joint), simple	86.75
Metacarpal, one bone, simple	20.00
Metatarsal, one bone, simple	30.50
Patella, simple	20.00
Temporomandibular, simple	30.00
Thumb, simple	20.00
Toe, one or more joints, simple	20.00
Vertebra, simple, using traction and general anesthesia	238.50
Suture or repair of joint capsule for recurrent shoulder dislocation	303.50
TENDONS, TENDON SHEATHS AND FASCIA	
Excision	
Baker's cyst (synovial cyst or popliteal space)	150.00
Lesion of tendon or fibrous sheath, or ganglion	65.00
Repair or suture	
Extensor tendon, single	
forearm or leg	78.00
hand or foot distal to wrist or ankle	52.00
Flexor tendon, single, finger, hand, or forearm	130.00
Transfer, transplant, or free graft of tendon, single	
Elbow to shoulder, knee to hip	216.75
Distal to elbow, distal to knee	173.50
NERVOUS SYSTEM	
Craniectomy, suboccipital, for brain tumor	650.00
Craniectomy, suboccipital, for section of cranial nerves	541.75

	Scheduled Limit
Craniotomy for drainage of brain abscess	325.00
Laminectomy for removal of intervertebral discs	390.00
Skull, burr holes, one or more, for ventriculography	100.00
Splanchnicectomy, unilateral	300.00
Splanchnicectomy, bilateral	360.00
Sympathectomy, cervical, unilateral	300.00
Sympathectomy, lumbar, unilateral	300.00
Sympathectomy, lumbar, bilateral	380.00
RESPIRATORY SYSTEM	
Antrotomy	
Intranasal, unilateral	70.00
Intranasal, bilateral	108.50
Radical (Caldwell-Luc), unilateral	216.75
Radical (Caldwell-Luc), bilateral	281.75
Bronchoscopy	
Initial	70.00
Subsequent	70.00
With biopsy	86.75
With removal of foreign body or tumor	108.50
Nasal polypectomy	
Single polyp	20.00
Multiple polyps, unilateral or bilateral, one or more stages	40.00
Pneumonectomy or lobectomy	433.50
Tracheotomy	86.75
URINARY SYSTEM	
Cystolithotomy	216.75
Cystoscopy, while resident hospital in-patient	
Diagnostic	50.00
With urethral catheterization	65.00
Cystoscopy with biopsy	50.00

	Scheduled Limit
Excision or fulguration of urethral caruncle	30.50
Pyelotomy, pyelolithotomy, pelviolithotomy	303.50
Removal of kidney	346.75

* * * * *

Schedule of Radiotherapy

This Schedule shows the maximum payments applicable to the respective therapies, including consultation, dosage calculation, materials and the preparation thereof, and the use of facilities. For any therapy neither specified nor expressly excluded, a consistent payment will be objectively determined under the Plan.

Teleradiotherapy	*Maximum Payment*
X-ray—1000 KVP and higher, radium, cobalt, betatron—per treatment	$ 15.00
X-ray—less than 1000 KVP, telecesium—per treatment	10.00
Radium and radioisotope therapy (sealed sources)	
Intracavitary or interstitial application of radium or radioisotope—per treatment	125.00
Application of radium or radioisotope plaque or mold—per treatment	15.00
Radioisotope therapy (non-sealed sources)—administered internally, interstitially or intracavitarily. The maximum stated is for all charges incurred during any 12 consecutive months for the condition shown.	
Thyroid cancer	250.00
Prostatic cancer	300.00
Thyroid ablation for cardiac disease	225.00
Polycythemia vera	100.00

Teleradiotherapy (continued)	*Maximum Payment*
Chronic leukemia	100.00
Metastatic cancer to bone	175.00
Ascites or pleural effusion, or both	250.00
Hyperthyroidism	150.00

* * * * *

Adjustments: If a covered person is disabled on the effective date of an increase in the Medical Expense Benefits, he will retain the same benefits he had before the increase became effective until he is no longer disabled. For this purpose, an Employe is considered to be disabled on any date that he is ill or injured and away from work. A dependent will be considered disabled on any date if he is confined at home or in an institution for medical care or treatment.

Your Weekly Contribution

Refer to Plan Summary (Part I).

PLAINTIFFS' EXHIBIT 11

THE PRUDENTIAL INSURANCE COMPANY
OF AMERICA
Willowbrook Office
201 Willowbrook Boulevard
Wayne, New Jersey 07470

Jeremiah Kelly, F.S.A.
Associate Actuarial Director

October 17, 1972

Mr. Robert A. Bussey
Corporate Insurance Manager
General Dynamics Corporation
Pierre Laclede Center
St. Louis, Missouri

Re: Administrative Services Only

Dear Bob:

A reasonable estimate of the incurred but unreported claims for those health coverages, which changed to an Administrative Services Only arrangement as of October 1, 1972, can be obtained by taking 26.99% of the paid claims for the twelve month period prior to the date as of which you are establishing the estimate.

The factor of 26.99% was determined as of July 1, 1972 based on a study of the actual lag in reporting of claims by your employes under your insured contract for the above health coverages.

Sincerely,

/s/ JERRY
Jeremiah Kelly, F.S.A.

JK:jh
cc: Messrs. Hawkins
Johnson
Zois

PLAINTIFFS' EXHIBIT 12

151 Farmington Avenue
Hartford, Connecticut 06115

James D. Holland
Secretary
Group Division

October 26, 1972

Mr. R. A. Bussey
Corporate Insurance Manager
General Dynamics Corporation
Pierre Laclede Center
St. Louis, Missouri 63105

Dear Mr. Bussey:

You asked that we provide you with factors which you could use to estimate the liability for open and unrevealed claims. We anticipate that we will continue to provide you with quarterly accountings. These accountings will show our estimate of the outstanding liability at the end of each quarter. If it is necessary for you to estimate a change in reserves on a monthly basis, we suggest you use the following factors:

Coverage	*Factor*
Basic Medical	95% of prior three months recorded claims
Basic Dental	109% of prior three months recorded claims
Comprehensive Dental	130% of prior three months recorded claims
Major Medical	188% of prior three months recorded claims

Very truly yours,

/s/ JAMES D. HOLLAND
James D. Holland
Secretary
Group Division
may

IN THE UNITED STATES CLAIMS COURT

No. 7-81T

GENERAL DYNAMICS CORPORATION, ET AL., PLAINTIFFS,

v.

THE UNITED STATES, DEFENDANTS.

(Filed: October 11, 1983)

ADDITIONAL FACT STIPULATION

Plaintiffs, by their attorneys, and defendant, by its attorney, stipulate for the purposes of this proceeding that the following statements of fact are true and correct.

1. Plaintiff's Exhibit 44 is a worksheet which sets forth: (a) the actual 1972 year-end self-insured accrual/reserve for medical care benefits by corporation after adjustments for the extended liability reserve portion and the Aetna drafts outstanding; (b) the 1972 year-end self-insured accrual/reserve for medical care benefits by corporation recalculated strictly in accordance with the percentage figures supplied by the insurance companies with adjustments for the extended liability reserve portion and the Aetna drafts outstanding; and (c) the payments by corporation made in the period 1973 and 1974 on medical care benefit claims which were incurred in 1972 or earlier after adjustment for drafts outstanding.

2. Defendant's Exhibit 21 is a true and correct copy of portion of plaintiffs' 1972 federal income tax return, consisting of pages 1 through 4 of Form 1120 and attached Exhibits 32, 32(a), 32(b), 32-R, 32(a)-R, 32(b)-R, 32-O, 32(a)-O, and 32(b)-O.

TYRONNE E. MCNOWN	J. WALDEN JOHNSON
Attorney for Plaintiffs	Attorney for Defendant

[43]

PORTIONS OF TRIAL TESTIMONY, SEPTEMBER 12, 1983

* * *

JAMES A. HAWKINS

having been first duly sworn, was called as a witness herein and was examined and testified as follows:

DIRECT EXAMINATION

By Ms. McNown:

Q. Would you please state your name for the record?

A. James A. Hawkins.

Q. What is your address?

A. 52089 Fallow, Horseshoe Bay, Texas, 78654.

Q. What is your present occupation?

A. Self employed.

Q. Have you ever been employed by General Dynamics Corporation?

A. Yes.

Q. When did you join General Dynamics?

[44] A. 1963.

Q. What were your positions with General Dynamics?

A. For the first four years I was in the engineering department at the Fort Worth division; for the remaining thirteen years I was in the corporate office in the Employee Benefits Department; the last ten years I was the Director of Employee Benefits, for General Dynamics.

THE COURT: You were in the engineering department, what were you doing there, in what capacity?

THE WITNESS: I worked in the environmental control system design group, and in the administrative side of the engineering department.

THE COURT: Were you an engineer by education?

THE WITNESS: Yes.

THE COURT: I see. Proceed.

By Ms. McNown:

Q. What is your educational background, Mr. Hawkins?

A. I have a bachelor of business administration, and a bachelor of science in mechanical engineering.

Q. You testified that you were Director of Employee Benefits for the last—what?—ten years that you were with the company?

A. Yes.

Q. When did you assume that position?

A. July of 1970.

[45] Q. Okay. What were your duties as Director of Employee Benefits?

A. I had the overall responsibility for the design, the implementation, and the administration of the various employee benefit programs throughout the corporation.

Q. When you say the "corporation" what are you referring to?

A. General Dynamics and the subsidiary companies.

Q. Did General Dynamics and their subsidiaries have medical benefit programs for their employees during some, or all of the time that you were Director of Employee Benefits?

A. Yes, they did.

Q. During what period of that time?

A. All of it.

Q. Had they had such programs for their employees prior to the time you were Director of Employee Benefits?

A. Yes.

A. In future questions I will use the term "General Dynamics" to include General Dynamics and its subsidiaries. Is that acceptable?

A. Yes.

Q. As Director of Employee Benefits, did you have any involvement with medical benefit programs that General Dynamics had?

A. Yes.

[46] Q. What was that involvement?

A. Coordination with the insurance companies; designing the level of benefits; representing the corporation in negotiations with unions concerning the benefits; and various other day-to-day administrative items associated with the benefit plans.

Q. Did you get involved in anyway in the claims handling in relation to the medical benefit program?

A. Indirectly, I did.

Q. What do you mean by "indirectly"?

A. The claims were handled out in the field. Occasionally, we would get feedback from the divisions to make decisions on particular cases.

Q. Would you describe what category of benefits were generally provided by the General Dynamics medical benefit programs?

A. We provided basic hospitalization, surgical benefits, made payments for doctor visits, maternity benefits, dental claims, and we had major medical claims as well.

Q. What level of plans were set forth under the basic medical coverage?

Q. For example we would have a hospital room and board allowance, and a specific amount would be paid for each day of confinement in the hospital. In the surgical area, generally we would have a fixed fee. We would have a schedule [47] of surgical procedures, and show in the booklets how much the plan would pay for those particular procedures.

Q. Under the major medical plans, what level of benefits were provided?

Q. After the employee has satisifed a deductible, which usually was $100, the company would pay 80% of the eligible benefits.

Q. Does that mean the employee paid the remaining 20%?

A. Yes.

Q. So, the General Dynamics plans were not designed to pay 100% of an employees medical expenses?

A. That is correct.

Q. When the medical benefits were insured, did General Dynamics pay anything to the insurance companies?

A. Yes.

Q. What did it pay?

A. Premiums.

Q. Did the insurance companies provide General Dynamics with any information from which General Dynamics could book its medical benefits expense, while the plans were insured?

A. Yes.

Q. What did it provide?

A. As part of the premium structure, there was a factor in there for their reserves and for their retention, [48] as well as their expected claim allowance.

Q. Did they submit any information to General Dynamics for which the corporation could make accounting entries for its medical benefit expense?

A. Yes, they would give us monthly costs per employee. And those cases where dependents were involved, they would give us a separate rate, showing the employee with dependents.

Q. What did General Dynamics do, if anything, with those per employee rates?

A. These rates were distributed to the divisions for them to use in booking their expense.

Q. Did there ever come a time when there was a change in the program, for providing the medical benefits by insurance?

A. Yes, in the fall of 1972, we switched to a self-insurance program.

Q. What do you mean by "a self insurance" program?

A. General Dynamics would assume the liability for the payment of the benefits as opposed to the insurance company.

Q. Once General Dynamics went self insured for the medical benefits, who was liable for the benefits?

A. General Dynamics.

Q. When General Dynamics changed to self insurance, did the type, or the level of the medical care benefits [49] change?

A. No.

Q. Earlier you testified that divisions and subsidiaries used this per person rates supplied by the insurance company to book an expense for medical benefits. After the change to self insurance, was there any change in that practice?

A. No.

Q. After the change to self insurance, did the insurance companies continue to have any role regarding medical care benefits?

A. Yes, they did.

Q. What were those roles?

A. They continued to provide us with the same information they had previously provided us while the benefits were insured. In those cases where they processed claims, they continued to process the claims so there was no change.

MS. McNOWN: Does the reporter have an exhibit 9?

(Pause.)

By Ms. McNown:

Q. Mr. Hawkins, I show you plaintiffs' trial exhibit 9. Can you describe what that is?

(The witness proffered the document.)

A. This is a facsimile of the medical portion of the booklet which we had when we went self insured. In this [50] particular one, it's for the Patternmakers at the Electric Boat Division, with an effectivity of December 1, 1972.

Q. So this plan describes the benefits under the medical benefit program after the change to self insurance?

A. Yes.

Q. Mr. Hawkins, I show you a document which has been marked and received in evidence of plaintiffs' trial exhibit 40. Can you describe that?

A. This is a facsimile of the booklet used for the salaried employees at the Ardmore location—Stromberg-Carlson, Ardmore. And the effectivity is October 1, '72, and it describes the benefits under the self insured program for the Ardmore employees.

Q. What were these booklets, plaintiffs exhibits 9 and 40 used for?

A. To communicate to the employees their medical programs.

Q. Are the booklets which I have shown you, similar or not similar to other booklets provided to other employees at other facilities?

A. Similar.

THE COURT: Now, by other facilities, you mean other General Dynamics facilities?

MS. McNOWN: That is correct. And General Dynamics I have been using the collective sense of the corporation and [51] the subsidiaries.

THE COURT: All right.

MS. McNOWN: It has been stipulated, Your Honor, that the booklets are, indeed, typical of the booklets distributed at the various facilities.

By Ms. McNown:

Q. Mr. Hawkins, while self insured did General Dynamics make any promises to the employees about providing medical benefits?

A. As part of their employment, I think there was implied promise that we would provide benefits to them.

Q. Specifically, what was that promise?

A. That if they were eligible and had expenses for benefits covered under the plan, that we would pay for them.

Q. Under the self insured medical plan, at what point did the liability for medical benefits become fixed for General Dynamics?

A. At the time the service was rendered.

Q. Was General Dynamics liable to pay for the medical benefits even though a claim form had not yet been filed?

A. Yes.

Q. Under the terms of the plan, if an employee received covered medical services in say, January, and his employment terminated in February, and he submitted a claim in March for his January expenses, did General Dynamics have [52] to pay for those benefits?

A. Yes.

Q. Even if a claim had not been filed until after the employee was no longer employed?

A. That is correct.

Q. Why?

A. Because the service had been rendered at the time the employee was – at the time the person was an employee of General Dynamics. Therefore, we had a liability for those benefits.

Q. Under the terms of the General Dynamics plans, if a covered dependent, say a student, received covered medical expenses in January, then graduated and went out and lost his covered status in February, and a claim was submitted in March for the January benefits, did General Dynamics have to pay for those benefits?

A. Yes.

Q. Why?

A. Because the service was rendered while the dependent was eligible for benefits.

Q. Under the terms of the plans, if General Dynamics terminated its program of medical benefits, could it refuse

to pay for claims for services which had been rendered to covered employees, prior to the termination of the plan?

A. No.

[53] Q. Why not?

A. Because the service was rendered while the employee was eligible.

Q. Under the General Dynamics plans, if a person who was not an employee, received medical services in say, June, and he becomes a General Dynamics employee in July, and in August he submits to the corporation a claim for those June expenses which he had received before his employment, would those expenses be paid?

A. No.

Q. Why not?

A. He was not eligible when service was rendered.

Q. From your work in the employee benefits department, were you familiar with the processing procedures for handling medical benefit claims?

A. Generally.

Q. Would you please describe, generally, the process for handling medical benefit claims for plans administered by the Aetna Insurance Company, when General Dynamics was self insured, in the latter part of 1972?

THE COURT: Let's go off the record a second.

(Discussion was held off the record.)

THE COURT: On the record.

By Ms. McNown:

Q. Mr. Hawkins, would you please describe generally, [54] the process for handling medical benefit claims for the plans which were administered by the Aetna Insurance Company after the change to self insurance around 1972?

A. Typically an employee would present a claim to the local employee benefits office at his or her respective location. The employee benefits office would verify eligibility for benefits.

Q. What do you mean by "eligibility"?

A. To see if the person submitting the claim was eligible to receive benefits. The employees benefits office would in turn forward this claim to the local Aetna claim office and the Aetna claim office would then calculate the benefits to be payable, and issue a check to either the employee, or if the employee had assigned benefits, we'd send the check directly to the hospital, or doctors involved.

Q. What do you mean by assigned benefits?

A. Rather than have the insurance company send the payment for benefits directly to the employee, the employee can, and usually can designate on the claim form that he would like to have the benefits assigned, which means that the payment will be made directly to the hospital or doctor.

Q. Is any material sent to the employee besides the check?

A. Yes, there is a claim payment form which shows the calculation of benefits; shows which benefits were paid; [55] and if they were benefits which were not eligible, it would also show that. It would give the employee the understanding as to what happened to his total claim.

Q. Would you generally describe the processing for medical claims for plans which were administered by the Prudential Insurance Co., around 1972, when the plans were self insured?

A. In those cases, the employee would submit the claim to the employee benefits office at the local division, and at most of the Prudential locations our own people did the calculation of benefits so they would physically have the claim in hand, and do the calculation, and send the information payment and the claim payment form back to the employee, or the hospital or doctor, directly. We did have a few locations where the Prudential processed the claims for us, because we were not staffed up, or didn't have the expertise to do that ourselves.

Q. Would you describe the degree of difficulty for company personnel in determining whether or not an employee or dependent was eligible for benefits under the plan?

A. It would be a fairly simple clerical procedure to match up the name against the payroll roster.

Q. What happened if an employee did not like, or understand the amount that had been calculated as his paid benefits?

[56] A. He would go to the employee benefits office, and seek clarification as to why something was done.

Q. And if he was satisfied with that explanation, that would be the end of it?

A. Yes.

Q. If he wanted additional explanation, what happened?

A. If he didn't agree with the information given to him by the local employee benefits office, he could have the local benefits office refer the case to the corporate headquarters for them to review it.

Q. And by the "corporate headquarters" would that be you and your staff?

A. Yes, that is correct.

Q. How large was your staff back in 1972?

A. In 1972, I believe we had only two people, in addition to myself, at that time.

Q. How frequently during the course of the year, would you or your staff have to act on—what? Appeals?—the handling of medical benefit claims?

A. Twice a month, maybe thirty times a year, or so.

Q. And that would be for all of the plans that General Dynamics had?

A. Yes.

THE COURT: How many people would be covered by all the plans?

[57] THE WITNESS: Oh, we're talking maybe 80 to 100,000 employees.

THE COURT: Okay.

By Ms. McNown:

Q. Did you, yourself get involved in decisions regarding individual claims?

A. Occasionally, yes, I did.

Q. In your experience were there many lawsuits resulting from the denial of medical benefit claims?

THE COURT: During what year?

MS McNOWN: In general.

By Ms. McNown:

Q. In 1972?

A. I don't believe that there were any.

Q. In the years that you were Director of Employee Benefits, what was the incidence of lawsuits resulting from the denial of medical care benefits?

THE COURT: And what years were these again, that you were Director?

THE WITNESS: 1970 to 1980.

THE COURT: Okay.

THE WITNESS: I don't believe we had any.

By Ms. McNown.

Q. Why did you have such a low incidence of lawsuits on medical care benefit claim denials?

[58] A. I think for the most part that the employees were happy with their benefits, and a very, very large percentage of the actual bills was paid, so that out of a $1,000 claim, with a major medical program you can usually figure that at least $800 is going to be paid, and in most cases, I would say that the payment exceeded 90% of the actual bill, so they were happy with the results.

THE COURT: How could the payment exceed 90%, when there was testimony earlier that only—that the agreement was just to pay 80% of the bill?

THE WITNESS: When you have a basic and major medical plan, there's some benefits that are paid under the basic—the 80% would not apply in that case.

THE COURT: So, under the basic you are testifying that General Dynamics paid 100%?

THE WITNESS: Not necessarily 100%, but over 80%. If a person went into the hospital and had a room and board charge, and we had an allowance for room and board at that time at, say about $60 a day, but the room charge actually exceeded $60. The excess would go over into the major medical plan, and after satisfying the deductible, it would be paid at 80%. Now, if the hospital only charged $60, then it would be paid at 100%

THE COURT: I see.

THE WITNESS: So you could have a situation where [59] the basic would be paying close to 100%, and then you could have other situations where the basic would pay fewer dollars but the excess would go over into major medical and be picked up there at 80%. But in total, generally speaking, you could expect at least 80% of the claim to be paid, if you had a major medical program.

THE COURT: All right. Proceed.

By Ms. McNown:

Q. Are all of the medical benefit claims denied, until they are paid?

A. No.

Q. At what point in the processing of a claim is a claim denied?

A. Only after the processing is complete and it is determined that denial is in order.

Q. Were the employees of General Dynamics informed that the General Dynamics plans would pay part of their medical bills, but not 100%?

A. Yes.

Q. And how were they told that?

A. Through the employee booklets given to them, which set forth the plan of benefits, the levels and the schedules.

Q. Was there any philosophy in the 1972 time period, regarding the administration of the medical benefit plans?

A. I would say that if there were any questions, we [60] generally would give the employee the benefit of the doubt.

Q. Why?

A. Simply to promote good employer-employee relationships.

Q. You testified earlier that approximately thirty times a year, employees would ask for the corporate office to consider the action taken on their medical benefit claims. Is that statistic true for the whole period that you were medical benefits director? The approximate 30 times a year?

A. I would say so.

Q. In your experience, what percentage of medical benefit claims are filed within three months of the incurral of the claim, that is, the rendition of the services?

A. I would say most of them—90%.

Q. Were any of the medical benefit plans the General Dynamics had provided to union employees?

A. Yes.

Q. Were the level of benefits and the types of benefits subject to collective bargaining with those unions?

A. Yes.

Q. To change the benefits provided under a plan for union employees, would General Dynamics have to negotiate such a change?

A. Yes.

Ms. McNOWN: That's all I have on direct, Your [61] Honor.

THE COURT: All right. At this time, the Court is going to stand for a luncheon recess, and let the defendant gather its thoughts for cross.

We'll come back at 1:30.

(Whereupon, at 11:48 a.m., the hearing was recessed to reconvene at 1:30 p.m., this same day, Monday, September 12, 1983.)

[62]

AFTERNOON SESSION **1:27 p.m.**

THE COURT: Please be seated. Off the record.

(Discussion was held off the record.)

THE COURT: (Back on the record.) We're ready for defendent's cross of Mr. James A. Hawkins. Mr. Hawkins, you are still under oath and sworn to tell the truth. Will you take the stand, please.

Whereupon,

JAMES A. HAWKINS

having been previously duly sworn, was recalled as a witness herein, and was examined and testified further as follows:

CROSS-EXAMINATION

THE COURT: Defendant may proceed.

MR. JOHNSON: Thank you, Your Honor.

By Mr. Johnson:

Q. Mr Hawkins, let me ask you; you mentioned earlier this morning that in your opinion the, or you were liable to reimburse a worker for medical services received, once that worker had received those medical services. Why is that so?

A. Because we communicated to the employees that they had a certain plan of benefits, and once the employee went to the doctor, or hospital, and had those services rendered, it would be our position that we would have a liability to make payment for those benefits.

[63] Q. What if the worker who received those medical services was injured while working on the job? What would happen in that circumstance?

A. Well, that would be a Worker's Comp case then.

Q. And so then, would that worker receive reumbursement under your medical plans?

A. Not if he were covered under Worker's Comp.

Q. What if that worker was injured while on a weekend in the Army Reserve? Would he be under your medical plan?

A. I would say yes, subject to any coordination with CHAMPUS, if that applied.

Q. Would you have any instances where—or, were there instances when a worker received medical services and filed a form and yet was paid zero?

A. Yes, if the worker were not eligible for benefits, we may go ahead and process a claim but because of ineligibility no benefits would be paid.

THE COURT: You're not saying the worker, himself, would process the claim? He would file the claim and you would process it?

THE WITNESS: Yes.

THE COURT: All right. Proceed.

By Mr. Johnson:

Q. Were there any other instances where the worker would receive zero?

[64] A. (No response.)

Q. I think one we mentioned was the worker was injured while on the job, and was under Workmen's Compensation. Would there be any others?

A. I can't think of any off the top of my head right now.

Q. What if it was a new employee and the injury had arose before the time that the worker was an employee of the taxpayer?

THE COURT: Are you saying "injury" as distinct from a disease?

MR. JOHNSON: Yes.

THE COURT: All right.

THE WITNESS: You're wanting to know if benefits would be paid from the General Dynamics medical plan?

MR. JOHNSON: Yes.

THE WITNESS: Not if he were covered under Workmen's Comp.

By Mr. Johnson:

Q. And what if you had a person who was injured on November 9, say, and then was a new worker of the taxpayer on November 15th, and then was in the hospital on November 19th, would he be reimbursed for the services he received on the 19th of November?

A. He was injured before he became employed?

[65] Q. Yes.

A. No.

Q. What would happen when the medical services that the worker received, had a recognized value of less than what was charged?

A. I'm not sure I understand that question?

Q. What would happen if you had a worker who was in the hospital and he had a broken hand, and the hospital charged him a very, very large amount for his medical services. Would he be reimbursed that whole amount?

A. He would only be reimbursed whatever the plan of benefits called for, for the particular hospital stay or surgical procedure. If the amount that was charged was more than what the plan paid, then obviously, the company wouldn't pay 100%.

Q. When would you know whether the medical services that were received in the amount that was charged, was more than what was allowable under the plans?

A. Once the claim had been processed.

Q. What would happen if a worker was injured, received medical treatment and never mailed in a form? In other words, never sought reimbursement.

A. As far as the medical plan of General Dynamics is concerned, there would be no action taken because there would be no claim submitted. And plus, if he was covered by [66] Worker's Comp, again we'd have no liability to pay him.

Q. When you have a worker that was injured and on the job, when were you liable to pay for their medical services?

Then that would be under the medical plans rather than worker's compensation?

A. If worker's comp didn't apply, we would be liable at the time that the services were rendered, and we would have an obligation to pay those benefits regardless of when the claim came in.

THE COURT: You wouldn't be liable when the injury occurred?

THE WITNESS: Yes, we would.

THE COURT: That's not what you said. You said you would be liable when the services were rendered. Do you wish to change your testimony?

THE WITNESS: As far as the medical benefits are concerned, once the employee goes to the hospital, or doctors, and receives services, liability attaches at that point.

THE COURT: All right, then, you're not liable once the injury occurred—at the time the injury occurs on the job? Is that your testimony? Do you see the distinction?

THE WITNESS: Well, I'm confused, because he is talking about a worker's comp versus the medical program.

THE COURT: All right. Why don't you repeat that question so we can get it straight for the record?

[67] *By Mr. Johnson:*

Q. All right. You have mentioned earlier that you were liable under the medical—the non-worker's compensation, the medical plan—once the medical treatment was conceived.

A. Yes.

Q. What would happen if the injury that resulted in receiving medical treatment was upon the job injury? When would you be liable, then?

A: From what standpoint? From a worker's comp standpoint—

Q. Non-workmens comp—the medical plan?

A. I would say that once the person that received the injury went to the hospital emergency room or whatever, if the worker's comp program didn't pay for those services, then we would be liable at the time those services were rendered.

Q. And what would happen if it was under workmen's compensation?

A. Then we wouldn't be liable because the benefits would be paid under the worker's comp program.

Q. When would you find out whether an injury had happened on the job?

A. I would say, the day that it happened.

Q. Was that information on the form that the worker sent in?

A. There is a blank on the form that asks if the [68] injury is work related.

Q. When would you know that the medical treatment that a worker had received was reasonable or not?

A. Reasonable from what standpoint?

Q. A reasonable charge.

A. We would know the amount of the doctors fee and the hospital bill upon receipt of the claim form.

Q. What if you had a worker who walked in and he mentioned that he was in the hospital last week and he had to pay a certain amount of money, and he wanted his money right then. Would he be reimbursed?

A. Assuming he were an eligible employee for benefits we would ask him to file a claim form, and submit a claim, and it would be processed.

Q. Would he be reimbursed if he filed no form?

A. No.

MR JOHNSON: That's all the questions I have.

THE COURT: All right. Redirect?

MS. McNOWN: Could I have one minute, Your Honor?

THE COURT: All right.

(Pause.)

REDIRECT EXAMINATION

By Ms. McNown:

Q. Mr. Hawkins, if an employee was injured on the job during the day, would there be a report filed normally by [69] somebody at the company that day?

A. Yes.

Q. So you would know the day that a job accident occurred that an employee had been injured that day?

A. Yes.

Q. If an employee went to the hospital and was charged an excessive fee for a surgical procedure, and a claim processor was at the hospital and looked at the bill that was rendered to that employee, on the day that the employee got the bill, would the claim processor be able to determine that that fee was excessive?

A. Yes.

Q. If a General Dynamics employee is injured and is covered under the workmen's compensation plan, those same medical benefits—or, the medical charges which are in relation to that workmen's compensation claim are not also covered by the medical benefit plan, is that correct?

A. Yes.

MS. McNOWN: That's all I have on redirect, Your Honor.

THE COURT: All right. Recross?

MR. JOHNSON: No, Your Honor.

THE COURT: Hearing that there are no further questions of this witness, this concludes the testimony of Mr. James A. Hawkins. Thank you very much, Mr, Hawkins, for [70] your testimony in this matter. You are now excused from thi Court.

(The witness was excused.)

THE COURT: Plaintiff may now call its next witness.

MS. McNOWN: Plaintiff calls, J. David Loftus. Whereupon,

J. DAVID LOFTUS

having been first duly sworn, was called as a witness herein and was examined and testified as follows:

THE COURT: Plaintiff may proceed.

DIRECT EXAMINATION

By Ms. McNown:

Q. Would you please state your name?

A. J. David Loftus.

Q. What is your address?

A. My address is 105 Deborah Drive, Coventry, Connecticut, zip code 06238.

Q. By whom are you employed?

A. Aetna Life Insurance Company.

Q. What is your current position?

A. I'm administer in the Group Claim Department.

Q. How long have you worked for Aetna?

A. Twenty-three years.

Q. Where is your office located?

[71] A. Currently our home office is located in Hartford, Connecticut. That's where I am now placed.

Q. How long have you worked in the insurance business?

A. For 23 years.

Q. So your whole insurance career has been with Aetna?

A. That is correct.

Q. Are you a college graduate?

A. Yes, I am.

Q. What was your major?

A. I have a bachelor of business administration, major in management.

Q. Briefly, would you please tell us what positions and duties you have had with Aetna, and the periods that are involved?

A. I was hired on July 18th, 1960, in our Rochester Group Claim Department as a claim representative. For a period of ten months, I was employed as a claim representative. My primary function was to investigate long term and short term disability claims, and to assist the processor in interpreting contracts, and the claims that they had—additional information. I then went into the government service in the army for a period of six months, at which time in December of 1961, I returned to the employ of Aetna; this time in Hartford, Connecticut as a claim examiner. The function of the claim examiner was to review those special [72] claims submitted to them by our field offices, which needed assistance. I worked there fifteen months, at which time I was promoted to an assistant supervisor to our Lansing office, which at time was in charge of the plan for the Michigan Department Civil Service. My job as supervisor was to assist the processors on the day-to-day handling of group claims.

I stayed in Lansing for a period of ten years, at which time the operation grew from six people to 72 people, as the plan also grew. When I left there in 1973, I was a supervisor, which today is translated as a claim manager.

I was transferred to the home office for purposes of establishing a planned program which would help us educate our processors in the handling of a dental claim. The dental business was growing very rapidly. We had a new plan of benefits and we were trying to teach the employees by themselves. This was an innovative task of self management and self teaching. We completed that work in about ten months at which time I was promoted to superintendent of the government-wide Indemnity Benefit

Plan, for which I am still in charge. But, later on, in 1982 of this year, my duties were expanded to include the northeast and the southeast region of our claim business, which encompasses ten regional offices.

I am responsible for the government life plan, those regional offices, and any aspect of claims which need [73] further review or assistance in our home office.

Q. You said in February of this year, 1982—

A. This year, 1982—I mean 1983. I'm sorry, yes.

Q. The claims work that you have done over the years what kind of claims has that been involved with?

A. It has been involving all aspects of group claims, life, temporary disability, weekly disability, long term disability, primarily medical and major medical, and vision and dental care.

Q. The current function that you have as claim administrator in the home office, what are the duties of that position?

A. As claim administrator, our function is to assist in both developing and disseminating information, such as, guidelines, interpretations, general procedures to all of our field offices, and on an individual claim basis, to respond to any claim need they would have, such as; if the operation that was performed was in question as to what actually occurred, we would use our resources in the home office, which of course would be our medical department, to actually review the operative report so that we could ascertain that the benefits that we were suggesting were available, were indeed available, and an additional amount wouldn't be due, or that there were no extenuating circumstances. That plus trying to keep abreast of the medical practitioning and the [74] medical community, as far as introducing new procedures as to what would be covered under the plan; as determining whether or not it is now considered a covered expense versus an investigational or experimental. This is all the realm of the home office maintained in Hartford.

Q. How large a staff do you have?

A. Currently I have nine people as examiners, but the examining units in the group claim department have eighteen people.

Q. How many medical benefit plans do you and your staff work on?

A. Besides the government-wide indemnity benefit plan, and a few target accounts, we literally have thousands within that northeast-southeast region.

Q. Has your experience, for the whole time that you have been with Aetna, related in part to medical and dental benefits?

A. Yes.

Q. It has been stipulated in this case that General Dynamics and its subsidiaries had insured some of their medical care plans with Aetna in 1972 and prior years, and that they changed to self insurance in the later part of 1972 for those medical care benefits.

Mr. Loftus, are you familiar with the methods and procedures used by Aetna's claim personnel in processing [75] medical benefit claims in the period around 1972?

A. I am.

Q. Were the methods and procedures that Aetna was using for processing medical benefit claims different if the claims were self insured, rather than insured?

A. No, they weren't. Actually, self insurance is transparent to the claim department. It's a reserve or financial arrangement.

Q. So the same policy and procedures would be used by the claims processing staff?

A. That is correct.

Q. So General Dynamics claims when they changed to self insurance would be processed the same by the Aetna claims processors as before the change, itself, occurred?

A. That is correct.

Q. Would the same claims offices at Aetna and the same personnel handle the General Dynamics case when it changed from insurance to self insurance?

A. Yes. They are the same people.

Q. Was there a particular department or division within Aetna that did the processing of medical benefit claims during the 1972 time period?

A. The Group Claim Department was responsible.

Q. Would you briefly describe the internal organization of the Group Claim Department in relation to [76] medical benefit claims?

A. Group Claim Department is primarily two functions; one is the home office, and that is where all of the data is kept in storage, and the claim department there, provides the raw material and resources to the field offices. The field office, on the other hand, has the responsibility of the hands-on payment of claims that they receive everyday.

The home office, therefore, is the instructional office. They provide manuals, the education, they also provide a resource on the review of any individual claim.

Q. And the actual processing of a claim is handled in the field office?

A. In the field offices, themselves, that is correct.

Q. You, in fact, operated a field office, is that correct?

A. Yes, in Lansing, Michigan.

Q. Would you briefly describe the qualifications and training of personnel who did the claims processing work, in the Aetna field offices?

A. Generally, the claim processor was female, age 20, with a high school education and one year of college, or the equivalent in the business field. These people were hired by us and trained.

The training period usually lasted six months, where we would start off with a basically easy claim, such as [77] hospital and surgery, and slowly, but surely, develop their expertise over a period of six months. During this period of time, they were under 100% supervision and audit in order for that work to be delivered outside of their unit.

At the end of that six month period, however, they are well versed in the handling of basic major medical coverages, the insurance product itself, the general description of our insurance coverages, and also coordination of benefits, and the general exclusion that should apply to a contract.

Q. All right. Besides these processors who are trained, and then who are at the lower level of processing, are there other people in the claims office or regional office who are involved in processing medical claims?

A. Yes. At the end of six months, these people would be assigned to a regular group claim processing unit. They were made up of anywhere from four to eight people. They were supervised by supervisors, and a supervisor reported to a manager or assistant manager in the office. There was a natural line of review there.

If the claim processor found that any of the claims exceeded the guidelines or even their expertise, they had the responsibility of calling that to the attention of their boss, who in turn used additional resources and, of course, the expertise to try to resolve the claim. There was also that person could utilize the assistant manager who [78] again had four to six years of experience in the handling of claims. If that particular claim could not be resolved at that point, they had the option of either—if it was a medical question, of either utilizing local peer review or medical consultants or of course, the home office. If it was a question of interpretation of the contract or what benefits should be paid, they would utilize the home office for interpretation.

Q. Would you describe the type of—or categories of benefits that are provided under a basic medical benefits plan?

A. Yes. First of all, by basic coverage, this is a coverage that allows benefits up front without any deductible or co-insurance. So, under our basic plan, the obvious coverages would be hospital, surgical, medical,

anesthesia benefits, and these benefits were payable and were available readily, without any deductible.

Q. Would you describe the types or categories of benefits provided by major medical plans?

A. A major medical plan was really devised as an umbrella, or major expenses. These expenses took into consideration those that might already have been available under the basic plan, but it also included a further scope of coverage; such things as, registered nursing services were covered under major medical, so, too, were prescription drugs [79] that required a prescription from a doctor in order to be obtained. These charges would be not available under basics, so therefore, after a calendar year cash deductible, generally $100, were reimbursed at 80%.

Q. Who pays the other 20%?

A. The other 20% was called the employees share, and the employee was responsible for that.

Q. All right. I would now like to go through the procedures used in processing the medical benefit claims in the 1972-1973 time period.

What is the first thing that happens in the work flow in Aetna regional claims offices—field office?

A. The first thing we would receive is the claim form which was submitted to us via the contract holder, General Dynamics. General Dynamics' responsibility at that point, would have been to take these bills from their employee, and attach to it a certification from which told us at Aetna, that these benefits would be available in accordance with a particular plan, for instance, as we discussed here this morning. The plans maybe different, depending on the subsidiaries. The processors would need this information later on to compute these benefits. The plans varied. Therefore, once we receive that in our office, we knew the individual and the type of plan and the specific plan they belonged to and the fact that they were covered under the

[80] plan, and we would be given the effective date of coverage.

Q. Okay. So, when the claim comes to Aetna, the eligibility of the claim, then, is already established?

A. That is correct.

Q. Once a claim form comes to the Aetna office, with that certification, what happens?

A. Once our claim office received it, we would open the mail and identify the plan, alphabetize it—all of the records that were in that envelope, we would then, through the administrative services, arrange to have any existing file that we might have for that family and family members be associated; that would be combined with the new or the write-in claim. That information would then go to the claim processor.

Q. Now you said you'd see that a file was "associated" what do you mean by that?

A. Right. By a file being associated, that at the Aetna, we had separate folders for every employee of General Dynamics and all of our businesses. This way, we had to relate to existing conditions, and sometimes these claims were ongoing. So, we would have to take into consideration what we have already paid, so we would avoid a duplicate payment. So all of that information was prepared by the administrative staff for the processor at the time that she wanted to process the claim.

[81] Q. So you maintained continuing files on employees and then pulled them when new claims came in?

A. That is correct.

Q. You said that the claims are alphabetized?

A. Yes.

Q. Why are they alphabetized?

A. They would be alphabetized for the facility, because certain units because of their size would handle a certain section of the alphabet of the large policy holders

like General Dynamics. For instance "A" through "L" might be the unit No. 1, so, and also it made it easier on the administrative staff to actually keep track of these manual files.

Q. So for a client as large as General Dynamics, certain processors would handle a certain segment of the alphabetical group of employees on an ongoing basis?

A. That is correct. Now, this was needed because we would try to put all of one plan into one or two processors hands, so that they would become familiar with the plan and reduce the possibility of error, or misinterpretation.

Q. All right. Once the file is pulled and prepared, what happens next? It goes through the process?

A. It goes to the claims processor. The claim processor at this point is looking at the bills incurred by the employee. He is looking also at the certification form [82] from the policy holder, the contract holder, and verify the individual, and verify that the bill is being presented were not previously submitted, and now he is pulling out what we refer to as a brief card. It gives a bird's eye overview of exactly what is the coverage. For instance, the brief card would tell us that there is a hospital benefit available. It would not describe in detail what the benefits are, other than saying we'll pay room and board at $60 a day. We will pay for 31 days of hospitalization. We'll pay miscellaneous fees of $1,000. That would be the sum total of information on that card. But that information was also available for surgery, anesthesia, medical, major medical. It would give us all of the pertinent information we possibly would need in order to process a claim. For instance, let's suppose that we receive a claim for a simple case of an appendectomy. By the time the processors look at that claim, we would have a hospital bill an anesthesist bill, a claim from the surgeon. We would even have perhaps even an ambulance bill. We would probably have a goodly amount of prescription drugs. The processors job

then, was to identify the plan and establish a definite amount as to what could be paid under the plan. For instance, under the room and board charges for the hospital. The processor was trained to take the hospital bill and physically divide it into three areas; number one, the room and board. The room and board benefit would show [83] the number of days confined, multiplied by the amount that we could pay. So, in this fashion we were able to develop the basic benefits available for hospital. The same for the miscellaneous fees. The miscellaneous fees are charges by the hospital that are not room and board. And the third category of charges that we would have would be those charges that we couldn't pay at all, such as television.

But by displaying it on what we call an explanation of benefit payment form, we would be taking and reporting to the employees, exactly what he gave us; hospital bill, dates incurred, amounts submitted; then we would show him how we would separate the bill into hospital room and board, and miscellaneous fees and non-covered items. And in the next column we would show what could not be covered, and we would explain by comment, why. The last column we would be showing him what we are paying under the first dollar benefits under basic, and from the third column subtracted from the first column, anything remaining went toward the major medical. The same theory went all the way through for the rest of the claim. Under surgery, for instance, the doctor might have charged $500. Under the particular schedule, $400 would be the basic benefit. So, $500 would be in one column; $400 in the next and a $100 balance went to the third column. as far as major medical.

Q. Okay. And once they have grouped this on the [84] explanation of benefits worksheet, payment sheet, what do they do after they have made those?

A. Okay. Once these categorizations are made, that is the first step towards identifying how the benefits are going to be made. For instance, for the hospital benefit, we would issue a draft generally to the hospital because most of them had a hospital assignment, a notice to us from the employee, please pay them directly, and we would issue at the bottom, notification that this benefit payment is going to the hospital for the hospital's portion. The same would be for the surgeon's portion. They were assigned too, generally. We would pay the doctor directly. The anesthesia, perhaps, could be assigned. But if we are talking about prescription drugs, there is no basic benefit for that. The remainder would have gone under major medical. So, when you come to major medical, you're talking about all covered expenses subtracted from that what was available under basic, and subtracting from the remainder on a calendar year basis, a hundred dollars. The remainder was paid at 80%. Those benefits generally went back to the enrollee, or employee, himself, because it was for usually the type of expenses were not generally assigned.

Now, this information, once it was displayed on the work sheet, it was tattletale to everyone, both the employer, the Aetna, and the employee, exactly how we took [85] those bills and processed them. It was also tattletale to our clerical unit, to actually issue those drafts based upon that certification.

Q. So once the processor has been through the claims file and noted the charges that are going to be paid and calculated them; the checks are written to the appropriate people, is the employee given—what? A written explanation?

A. Yes. Right, gets a copy of the written explanation. The policy holder gets a copy. And, back in those days, we also sent an actual copy of the draft along with the employee's so he could actually see where these monies are going.

Q. Okay. What you've just described sounds like a relatively trouble free type of case. What percentage of claims fall in that category?

A. We would figure that anywhere between 94-95% of the claims would be routinely handled in that fashion, because of the plan design and the specific and certain ways of being able to take exactly what was available.

Q. And for this type of a claim, who in the regional office would be involved in calculating and processing that claim?

A. Those claims would be paid by the processors, themselves.

Q. Would a supervisor have to get involved in those [86] 94% of the cases?

A. No, not at all.

Q. So the supervisors at the regional offices get involved in what per cent of the cases?

A. Anywhere from 5-6% of the claims.

THE COURT: Is there a money limit that the claims people can pay out?

THE WITNESS: Yes, Your Honor. There is a definite limit for each job description. The younger would have a $5,000 limit; where the supervisors would have $10,000, back then, and the manager, of course, had plan limits.

MS. McNCWN: Okay.

By Ms. McNown:

Q. Of the group of claims that supervisors might get involved with, that you said 5-to 6%, how many of those would require—now, the supervisors in a regional office, is that correct?

A. That is correct.

Q. How many of that 5-to 6% of claims would require input or consultation from the Aetna home office?

A. About 1% of what they reviewed, was reviewed by us.

Q. One per cent of . . .

A. Of their 5%.

Q. Of their 6%, or 1% of all claims?

A. No, 1% of their 6%.

[87] Q. Okay. So we're talking not about 1% of the total claims, but 1% of the 6% that the supervisors work on?

A. That is correct. That's right.

Q. Why is Aetna able to process such a large portion of the claims without supervisory review?

A. Primarily, it in on plan design. Secondarily, it is because of the education that the processors are actually receiving, and the fact that most of the procedures they are looking at, is mimicking exactly what exists in nature. We know what the doctors are going to do for a tonsilectomy, and what it is going to look like. We see what the hospital bills are, and we are very easy to instruct these people as to how to recognize the portion that is covered and to the extent that it is.

Q. Would you list some of the categories of claims that would require a supervisor's review?

A. Right. Primarily, I think it would be easier if we wnet down the line of coverage. For instance, if we were talking about a hospital bill, what would a supervisor be looking at? A supervisor would look at a hospital bill, if in the case of the appendectomy—we would know that an appendectomy usually requires a confinement of five days. If there was a confinement of ten days, the processor would say that that appears extraordinary, and why? The supervisor would have to look at that claim. Under the surgical portion, [88] the processors are very familiar with the charging patterns for specific procedures and if there was an excessive—an outlandish difference between what they were normally used to seeing, they might ask the supervisor for instructions.

Of course, there are now and then, new procedures that are introduced, that are not even in our schedules, even the

one that we publish in the home office, and this requires supervisory review and also perhaps home office involvement, to determine is this generally a covered procedure? Is this generally accepted in the medical society?

Q. Okay. If a claim comes in, for example, a surgeons bill which is considerably greater than what the processor knows to be the fees charged for that procedure, what happens to that claim?

A. That claim—I think what we should do again—I hate to use examples, but it is easier for me—if we were to look at the example of the appendectomy, let's suppose that the going fee is $500. Our processors, being in a region, are very familiar with the charging patterns within that region, so they are able to quickly spot an exorbitant amount. So in the case of a $500 fee, $550 would not be deemed exorbitant, but $1,000 would. The first reaction that our processor would have, is that there is not enough information to handle that claim. So the processors would go and seek additional information, or instruction from the [89] supervisor.

Q. Why does the processor say there isn't enough information to handle the claim?

A. Because, arbitrarily you would think that if $500 was the going rate, we should just automatically deny the balance of $500. We have certain rules and regulations among the paying of a claim that will show, or clue in the processors of what is exorbitant, and if the fee that we are paying is generally 20% higher, than what we consider normal, that is a clue to the processor that something is lacking. In the case of the appendectomy, there have been occurrences where the records that we received showed appendectomy, when really we were talking about a gall bladder, too. But, this information then is gleaned by the claim office. The processor would call the doctor's office for a quick check to say, "Are you sure that is all it was?" And, if they were certain that the doctor was right, that

what we got was sufficient, we would still have to get the operative report, to send it into the home office for a medical review, because we would not be able to just routinely deny that exorbitant fee, in that example, as "I'm sorry, it exceeds our normal fee. There is something missing on that charge. The supervisor would look at it to determine what that particular doctor—normally charged $1,000. Now, if that's the case, then we would have a certain position that we would have to take; [90] notably, $400 was covered under basis; $500 is allowed under major medical, and the $500 difference is what the doctor has charged is just not covered under your plan.

Q. If the request for information from the doctor shows that a gall bladder removal was involved at the same time an appendectomy was performed, what is the claims processing response to that?

A. Okay. The claims processing responsibility is to further document that file with the fact that they did check with the doctor's office and here's the additional evidence that came in. Each file has got to stand on its own merits. So, with that, the processor is instructed to so put that information into the file and it is that information that we are allowing to show our auditors as well as those from the contractor holder, as to what we used in order to accept that entire fee.

Q. So, if you see that additional procedures were performed, you would pay a higher fee than what the bill had first looked like?

A. That is correct.

Q. Or, was called for?

A. That's right.

Q. How was Aetna able to determine what a proper surgeons fee is for a procedure like an appendectomy?

A. The processors have available to them, a printout, [91] which is labeled obviously, the prevailing fee printout. By prevailing fee, I mean that in a certain geographic area

which we call medical expense area, for instance, St. Louis is a medical expense area. For a tonsillectomy, because a tonsillectomy carries a certain CPT code—Common Procedure Terminology—it is a five digit number. It locks right into the fact that by our computer, this is the code for an appendectomy. We then put into our computer the fact that the doctor is practicing in St. Louis by his zip code, so that when we see all of the claims coming from St. Louis for an appendectomy, this information going into our computer, is then allowing us to produce a report that will tell any of the processors involved in the St. Louis area, precisely what the prevailing fee is. Again, prevailing means what most doctors are charging.

Q. How do you establish prevailing?

A. Prevailing? Prevailing establishes itself. We see that prevailing to be what most doctors would charge, and generally you are seeing something falling at a percentile of between 75-and 85%. Let me see if I can further explain that. Of all the charges in St. Louis for a tonsillectomy going into our computer, we are reporting precisely what the doctors are charging. This information then is tallied in a percentile; 5, 25, 50, 75th, 85th, 95th and 100 percentile, so that we see all of the charges displayed and we have an [92] actual falling where the most doctors will charge at or below.

Q. And what is the dividing line, I gather that you use?

A. The dividing line is the bulk of the physicians. So, in some instances, a prevailing fee may be the 75th per cent. A prevailing fee on the other hand might be a 95th per cent, but the preponderence of them fall at or below the 85th percentile.

Q. Now when you say it falls at the 85th percentile, that means you are paying—

A. 85% of the claims that we receive for doctors in St. Louis, for that procedure, at that level or below. Of

course, if they charge less than that level, we'll accept that as the covered expense.

Q. Okay. If a claim comes in—so Aetna is actually collecting on an ongoing basis the information as to what doctors in a geographical areas are charging for a particular procedure?

A. Yes.

Q. And was it doing this in 1972?

A. We had started to.

Q. Now, did Aetna also collect information regarding what individual doctors were paying?

A. We do today, but we were not—that information was not available to us as readily in 1972.

[93] Q. How does Aetna use the information that it gets regarding prevailing fees?

A. Under our major medical contracts and today, under our basic contracts where they will say they will pay the prevailing fee under surgery, we must determine what that prevailing fee is. So it is our responsibility to establish what most doctors are charging for a certain procedure. This is the amount which is allowable both under our basic and/or major medical contracts.

Q. Does Aetna try to pay less than the prevailing rate in a locality?

A. No, we do not.

Q. Did Aetna's claims handling decisions on prevailing rates charged by doctors for particular procedures in 1972, result in a lot of disputes with employees about the amounts that Aetna was paying?

A. No.

Q. Are you aware of any statistics as to any lawsuits that were filed in connection with Aetna's decisions regarding prevailing rates for surgical procedures?

A. Yes. I do.

The COURT: Defendant, do you wish to look at the notes the witness is bringing out?

THE WITNESS: I have some notes, here.

MR. JOHNSON: No, Your Honor.

[94] THE COURT: All right. Very good.

THE WITNESS: From the period of September 1st, 1971, through December 30th, 1982, we had a total of 229 lawsuits, with respect to prevailing fees alone.

THE COURT: Would you repeat that, please?

THE WITNESS: Okay. From September 1st, 1971 through December 30th, 1982, the lawsuits that the Aetna participated in were 229. Now, it's not known as to when most of those claims would have been, I don't know if it is across the board. I would presume that the majority of those claims would have been early on in 1972 and '73.

THE COURT: 229 out of a possible—if everybody protested, what would the number be?

THE WITNESS: 229 out of the total claims that we paid in 1982, alone, were 33 million.

THE COURT: 33 million.

By Ms. McNown:

Q. So the 229 is for almost a decade and in 1982, you paid 33 million claims?

A. 33 million claims.

Q. Just in that year alone?

A. That's right.

Q. So in a decade of doing medical benefit claims, Aetna processed—what? Hundreds of millions of claims?

A. In 1979 we were doing 16 million, so I think we are [95] talking at lease 15 million claims a year, for the duration.

Q. As a result of Aetna's use of these computer collected, prevailing rates, did Aetna experience any higher incidence of cases going to a medical peer review com-

mittees regarding the determination of what the prevailing rate was?

A. Well, we had more notoriety about it. There were not that many more claims that were reviewed by peer review. There was an education process going on in 1972, because we were required by our contract holders to help in the controlling of the costs and also to be able to be more definite as to what the prevailing fees were.

THE COURT: So, in Aetna's basic plan, is it your testimony that there is not a certain sum, such as we pay $300 for appendectomies, period, That's not—

THE WITNESS: Your Honor, back in 1972, it was that way. We paid a certain amount because it was in the brochure that this is what we pay. But the current procedures and the current plans that are available, are called, Relative Value Plans, and we pay the prevailing fee even under the basic plans.

THE COURT: When was that change made?

THE WITNESS: I'm unaware of that.

THE COURT: Okay.

THE WITNESS: But these are the more commonly sold plans.

[96] THE COURT: All right.

By Ms. McNown:

Q. Back in 1972, did the major medical plan have in it, the concept that you paid the prevailing fee for doctors and surgical procedures?

A. Yes, we did.

Q. Okay. So that concept applied to major medical plans in 1972, but not basic medical plans?

A. That is correct.

Q. The basic medical plan had its dollar schedule of benefits for procedures?

A. Correct.

Q. You also mentioned that claims would involve supervisory review if a claim came in that had a longer hospital stay listed on the bill than what the processor would expect to see. How does the processor know how long a hospital visit for an appendectomy should take?

A. We have guidelines prepared by our home office medical department on the most common admissions, and these guidelines are at the processor level. It is a screen that they use and if it exceeded that screen, that was their trigger to refer this for further review.

Q. And if a processor saw that a particular claim involved more days than what the Aetna standard indicated, what would happen to that claim?

[97] A. The claim would be reviewed for the—in order to, again, develop additional documentation so that we can make a claim determination.

Q. If you got additional documentation that indicated additional procedures had occurred during that hospital stay, what would you do?

A. Or an underlying condition, or extenuating circumstances, that was all taken into consideration, and we would have honored the additional part. We were trying to pay that claim in full, but our guidelines would only let us accept whatever the going rate was. So, our job was to develop more documentation which would allow us to pay a better benefit.

Q. If If a claim came in which involved a new procedure, what would happen to it?

A. Generally, those are immediately forwarded to the home office, because no one in the field office is aware of what it is. At the home office level, our medical department has the facility of dealing with the national level of the various medical facilities—specialties, I should say—as well as the American Hospital Association, and having that specialty report back to us as to is this experimental,

or is this now acceptable treatment?

Q. And in responding to new medical procedures, is Aetna trying to follow what the medical community accepts as [98] established procedures?

A. That is correct.

Q. Does Aetna home office, as procedures become established, notify the regional offices?

A. Absolutely. It is imperative that we do that because it will cut down on the delay that each of the other offices might have in the development of the same information, and also gets the work off of my desk.

Q. So, once Aetna finds that a procedure A has become medically accepted, it will notify the claims offices?

A. Right. And we do this either through instructions such as information letters, or if it is a matter of surgery, of updating our manuals to reflect that procedure and information.

Q. Once the claims office is notified that new procedure A, is now an accepted procedure, would they continue to send that into the home office?

A. No, once the procedure is established, then that becomes a matter of course for the rest of the business.

Q. How many people are in the home office working on consultation on medical benefit claims, versus people in the regional offices?

A. Our regional, or field offices, have about 3,000 people and the majority of them are processors. In the home office we have 18 claim reviewers, or examiners as we refer [99] to them, and they have administrators, so I would think about 20 people, tops. And we funnel those claims from the home office to the various home office departments in order to gain the expertise or position on whatever the problem might be.

Q. So your 18 to 20 people who are claim consultants, handle the consulting work generally for all of Aetna's medical benefits business?

A. That is correct.

Q. If a claim comes in without complete information what happens to it?

A. If we receive a claim and the necessary evidence is missing, for instance, if we receive a bill from a surgeon that says $350 with no description of the procedure, we would have to document the file as to what actually went on. In that particular instance, we would pick up the phone and call the doctor's office and say "What was the procedure? You forgot to include it." If it was a hospital bill where the assignment was received and the total bill was presented but not an itemized statement included, that would have been a clerical error. We would ask for an itemized bill and that would be a telephone call. If it is a procedure with a doctor where his charges are exorbitant, according to our rules and guidelines, we would write him a letter and say, "Were there any extenuating circumstances? If not, could you [100] supply us with a copy of the report so that we could determine our benefit."

Q. When Aetna investigates claims, is it involved in the activities that you've just described?

A. Yes.

Q. Is that typically the extent of your activities in investigating a claim?

A. Extent of the activities, means is it limited to that?

Q. No, is that typically what you do?

A. It is typically, yes, very typical. Right.

Q. Are all claims paid only at one time, or can there be partial payments?

A. There are partial payments. We pay the benefits

that are certain and definite, and if there is a question, or if, for instance again, if the hospital bill—if we knew that the ten day stay was reasonable, and expected, and we see 20 days, we would honor the ten day stay and advise the employee that there's nothing he has to do, but we are asking the hospital for additional records to make a determination with regards to the balance of the claim. The same would hold true with the surgeon. If we allowed a certain amount for the surgeon's charges as to what we would accept, the balance, we would still tell the employee we are checking into the balance.

[101] Q. If Aetna is attempting to obtain more information to process a claim, does it deny the claim while it is waiting for that information?

A. No, we can never deny a claim until we are certain of our position. To do so would put the Aetna and the employee and General Dynamics in an embarrassment, once the additional evidence came to light. It is our job to develop that claim on behalf of the employee and General Dynamics, so that the justified payment is made the first time that we make it.

Q. When does Aetna take action which constitutes denial of a claim?

A. When all the facts are in, and we see that the benefits are paid in accordance with the plan. For instance, in what was disclosed here earlier, the case of the Workmen's Compensation claim, the processor would have caught that up front, to say this claim was submitted to us in error. It should be under the Workmen's Compensation Plan, or the plan was in effect on a certain date, but all the charges were incurred prior to that, that would have been caught up front and we would have denied it. And in our denial we quote the—or refer the employee to the brochure, or the certificate of insurance, that will allow them to understand how we handled the claim in that way, rather than a benefit that he might otherwise have anticipated.

[102] Q. All right. But prior to obtaining information which gives you a concrete basis for denying a claim, you do not take action to deny the claim?

A. No, we do not take any action, that's correct. We take the position of now we have the claim and now we must develop additional information. We put the claim employee on notice the fact that we received it but we haven't done anything with it, yet, as far as the benefit. We need additional evidence and we're arranging for that. Now, sometimes we may ask the employee for it, which we'll write them a letter and say, we need this or that from you and what happened.

Q. What philosophy does Aetna have in administering medical plans?

A. To pay everything that we owe.

Q. Once the facts are already known on a claim, if it is not clear whether an item is covered or not, what does the Aetna do?

A. Well, those claims are called the "gray area" claims. If we cannot make a determination to prove that it should be denied, those are ruled in the employees favor and we extend the benefits to them.

Q. So you pay the claim?

A. We pay the claim.

Q. The processing procedure that you're discussing [103] obviously takes some time. If you had a processor in the hospital waiting room or in the accounting section of the hospital, so that when the employee left the hospital, after a stay for surgery and was given his bill. He provided it to the processor at the hospital. Would the processor be able to determine how much was due on that claim on that day?

A. Yes.

Q. Why is that?

A. Because number one, we would have identified that this was a covered member of the particular plan, and

under the particular plan, we would have the evidence to us as to what benefits were available, and on a schedule basis there would be no problem in identifying the benefits available at that time.

Q. If the bill appeared to the processor to be higher than anticipated for the procedure which was performed at the hospital, could the processor obtain input from other Aetna consultant people by telephone, and make a determination about whether additional expenses were due or not?

A. Yes.

Q. And that could be done on that day?

A. Yes. The best resource on that day would be the doctors themselves, because they would be right handy to find out what was going on.

Q. So you could ask them if additional procedures had [104] been performed and could justify higher fees?

A. Right. Was this his customary fee? Were there extenuating circumstances, like getting him out of bed at 3 o'clock in the morning to have a tonsillectomy.

Q. You have reviewed the General Dynamics medical benefits plans, have you not?

A. Yes, I have.

Q. The General Dynamics plans have a provision for coordinate benefits, don't they?

A. Yes, they do.

Q. What is coordination of benefits, and how does it work?

A. Coordination of benefits is a feature that allows us to consider benefits that might be available under another plan. The most common case of coordination is where the husband and wife both work and both have a group plan.

THE COURT: Isn't that against the—violative of the rules of—I know you're not supposed to do it. Is that violative of a rule in the Aetna plan or any other Blue Cross/Blue Shield plan?

THE WITNESS: Your Honor, that they can have both insurances?

THE COURT: Yes. I know with the Federal employees, we're not allowed to do it.

THE WITNESS: That's right. That's right. You [105] cannot have dual enrollment.

THE COURT: So, anybody else can, is that what—

THE WITNESS: No, no. In this instance I was suggesting that the employee might be working for General Dynamics but the wife works for someone across the street, another plant.

THE COURT: Oh, I see, two non-Federal employee spouses?

THE WITNESS: That is correct. Right.

THE COURT: I see. All right. Proceed.

By Ms. McNown:

Q. Okay. You were describing to us, coordination of benefits and how it works.

A. Well, first for instance, if someone has had the Federal plan and also had General Dynamics plan, in the absence of—

Q. Let's not do a Federal plan.

A. But they had more than one plan. In the absence of coordination, both plans would pay the normal benefits, and the family would have made a profit on being ill. So, as a result of a response that the insurance industry had with the National Association of Insurance Commissioners, back in the '60's, they developed an order of benefit determination and coordination of benefit provision in all of our contracts. They provisions allowed the plans to cooperate, exchange [106] monies, and they exchange information, so that when both plans made their payment, 100% of the allowable expenses would be paid. But by order of benefit determination, the industry had accepted general guidelines under which they would operate. Let's for instance take—

Q. Is the net result that the employee receives 100% of his covered benefits, but doesn't make anything extra?

A. That is correct.

Q. And this is done by determining who pays first, in what order?

A. That is correct. And in the example of the husband and wife, if the claim was incurred by the wife, the wife's carrier would pay first. The same is true for the male employee. His claims would be paid by his plan first. In the case of a child, the fathers claim would pay first; the mothers would be picking up the balance.

Q. That child—you said the fathers claim, do you mean the fathers plan?

A. The father has incurred the expenses on his own behalf, his claim would be paid under his plan first.

Q. Right. The child?

A. The child—if we are talking about children, those claims are normally paid under the fathers claim—or under the father's insurance first, with the mother's plan picking up the balance. There is another instance, though, [107] where one individual may be retired and have a new employer, and have more than one group plan, and in that instance, whatever plan was the earliest plan, is the primary one.

Q. Under the General Dynamics medical plan, if the wife of an employee receives medical services in June, and she is not employed at that time, and later, say in August, she becomes employed and covered by a group medical plan, does coordination of benefits apply to her June claim?

A. No.

Q. Why not?

A. No, because in June there was only one coverage and the coverage that was available then, when the claim was incurred, would be liable to pay that claim.

Q. Doesn't coordination of benefits result in a lot of difficulties in application?

A. No. Up front, as soon as that other plan is known, the insurance companies cooperate among themselves, and determines who goes first and who goes second, and the employee becomes aware of this and they follow the order of benefits. So the first carrier pays its benefit, a copy of that explanation of benefit payment form, goes to the employee. He takes it and sends a copy of the bill on to the secondary carrier and they know exactly what to do. If the employee takes the option of sending both carriers the bill, simultaneously, the carriers get together and determine how [108] we are going to pay it.

Q. And are all the carriers following the same rules?

A. That is correct. They are.

Q. How do you know when processing a claim that there is more than one plan?

A. The claim form itself is designed to beg the question from the employee, are there more than one plans or employers in the family. Now, the first question is, is there anyone else in your family that is employed? The next question is, is there any other insurance? This allows the processors to take this information into consideration. If that fails, we still have the hospital and doctors, their bills and their forms, to give us the same information as to whether there is two or more plans involved.

Q. If, when the employee gets out of the hospital and renders his bill immediately and the processors in the hospital waiting room are waiting to do the processing, can she also on that day determine the benefits of coordination or benefits involved?

A. That is right, especially if we are primary.

Q. If you are primary. . . .

A. We pay our routine benefit.

Q. And if you are secondary?

A. We pay a benefit which when added to the primary's benefit, gives them 100%. And the day that we are at the [109] hospital, we would have to have the other

plans processor there, too, to tell us what they were going to pay as a primary carrier.

Q. If the two processors were there you could work out the full benefit payment for that employees stay in the hospital?

A. Absolutely. Yes.

Q. The General Dynamics plans provide limits for coverage for pre-existing conditions, do they not?

A. That is correct, they do.

Q. How do the processors handle this exclusion from the plan?

A. The processors are given instructions that, to compare the effective date of coverage for any new claim, if the effective date of coverage is recent, or if the effective date of coverage is showing a current condition that may be judged chronic, like gall bladder, they would look to see if during the three months preceding the effective date of that coverage, if there was any bills submitted or any charges made by a doctor or a hospital, or a provider of care, for that condition, and if so, the benefits would be denied. Now, these would be denied on the pre-existing condition, which sort of dovetails with the fact that if they have just joined our plan, and through our denial, if they were coming to us from another plan, the other carrier would be paying [110] those benefits, if there was total disability for that on-condition for upwards of a year.

THE COURT: What if there was no prior carrier?

THE WITNESS: Then there would be no coverage for that at all, Your Honor, under any plan.

By Ms. McNown:

Q. If it is found from the claim file, and any additional information that is received on the claim that there was no charge for that condition within this ninety day period, what happens?

A. Even if it is a chronic condition, that claim is honored and regular benefits apply.

THE COURT: Would you give an example?

THE WITNESS: For an example, I think gall bladder, because that is a chronic thing that plagues those people who have it. We would expect by the diagnosis itself, to say if they were covered the first of July of this year, and we see expenses incurred in July and August, there is a high suspicion that that is an ongoing claim, or an ongoing condition, but we would contact the doctor, or if it is a hospital bill, contact the hospital, to verify whether there was any confinement or treatment during that ninety day preceding effective date of the coverage. And if it wasn't, even though they might have had this condition most of their life, if they were going through that period without the [111] treatment, they would have the coverage under the General Dynamics plan.

THE COURT: What if he was treated by an osteopath?

THE WITNESS: Anyone, Your Honor.

THE COURT: Or a chiropractor?

THE WITNESS: Yes, for that condition. It would have to be for that condition.

THE COURT: Yes. How would you find out if he was treated by a chiropractor?

THE WITNESS: We would ask him. In other words, the bill we are looking at, would be generally the family physician, the one that would have been treating him right along, and the bill itself is tattletale as to whether or not, did you see him in 1978 and then 1983, on his ongoing claims. But it is based upon the evidence that we have at the time. Any and all doctors associated with that first submission, we would have to check back to see if there was a pre-existing condition.

THE COURT: All right.

By Ms. McNown:

Q. Now a pre-existing condition only applies to a new employee, is that correct?

A. That's correct.

Q. So, for most of the work force, it is not a problem?

[112] A. That is correct.

Q. Does the administration of the pre-existing condition exclusion of the plan, lead to disputes with the employees?

A. No.

Q. Why not?

A. Well, while an employee might be disappointed, we refer—when we have identified that this indeed was a pre-existing condition, and treatment was rendered during that period, before the effective date of the coverage—we denied the benefits and quote to them the reason why we are, and that references to their certificate or their brochure, as to why we have applied it.

Q. And to deny benefits, you would have to have found a charge within the ninety days?

A. That is correct—treatment.

Q. Do the General Dynamics plans have a time limit for filing of claims?

A. The brochure and the contract typify a period of ninety days under the basic, by which claim must be submitted, and under the major medical within one year from the date the expense is incurred.

Q. Do employees usually submit claims within the ninety day period?

A. Yes, they do, because those are first dollar [113] benefits that are available. There is no deductible or employee share needed, so they are quick to submit the claim for benefits.

Q. Because they get reimbursed?

A. Right away.

Q. What happens if a claim is filed beyond the ninety day period?

A. If the claim is filed beyond the ninety day period, that claim is handled routinely upwards of two years from

the time that it is incurred. In other words, the documentation that we have in those employee handouts, is to encourage early submission of claims, so that we have the resolved claims up front. It also helps us in the claim department because we only maintain those employee folders—those family folders, for upwards of two years, otherwise, it becomes a clerical problem.

In addition to that, we notice that most of the major medical claims come to us as soon as the deductible is over and usually that is at the beginning of the year, when people sit down to figure out their income taxes. That's when they first realize that they have a major medical benefit available. So, if the claim comes in, usually at the end of that time—but upwards of two years. We have evidence available to us that we have not paid that claim before, and we routinely accept those claims. That provision [114] is in the contract to protect the plan from any unjust claims, where we would be frustrated as far as our attempts to evaluate or to investigate it. If claims are submitted beyond that period, we would still go further and ask for an explanation as to why they were submitted to us. And, in the case of estates, or something like that, these are justifiable reasons and we might even have to go back and dig out some old files to prove that we hadn't paid it before. But, we give credit, or waiving our right to deny our claims even at that point.

Q. So you don't check into why there was a delay in processing the claim unless it is submitted—I mean, filing the claim unless it's submitted for processing more than two years after the incurral of the expenses?

A. That's correct.

Q. And, even if it is submitted after two years, you will process and pay benefits if you can?

A. If we can, right. We would have to develop additional evidence there to show why we still continued to pay the benefit.

Q. What number of claims are filed more than two years after the incurral of the expenses?

A. That's real rare. Predominantly, the ones that are forgotten, or put in a shoebox by the employees, or in the case of an employee death where the wife finally finds [115] someone to help her out.

Q. What percentage of claims, in your experience, come in within twelve months?

A. The majority of major medical claims are submitted within twelve months. The majority of the basic plan benefits—those first dollar benefits—are submitted within ninety days.

Q. By "majority" are you just saying 50%, or something higher?

A. Most. Most. I would say close to 85-95%, because the hospitals today are demanding that money as quickly as they can. We have even been asked to pay for on-going hospitalization where the patient is yet to be discharged from the hospital, and the hospital will send us interim billings and we pay them as they are received even though the patient has yet to be discharged.

Q. Under Aetna's insured benefits coverage—We have gone through testimony regarding the processing for medical benefit claims. Are the processing procedures which you have described this afternoon, procedures which would cover the processing of General Dynamics medical benefit claims in the 1972-'73 period?

A. Yes, they would.

Q. Have over the '70's, over those ten years, have there been changes in the way claims are processed under [116] medical benefit coverages?

A. No. They are substantially the same.

Q. Under Aetna's insured medical benefit coverage, when does Aetna's liability attach?

A. The contract has a definition of "date of incurred". A claim is incurred on the day on which the services rendered, or the supply is purchased.

Q. And that is when Aetna's liability attaches?

A. That is correct. That is right.

Q. If an employee receives services prior to the day he is employed by General Dynamics, and he submits the claim for those services after he becomes employed by General Dynamics, what happens to that claim?

A. Well, that claim is denied because the expense was incurred prior to the effective date of his coverage under the plan.

Q. If services are rendered when an employee is employed and covered by the plan, and then his coverage under the plan terminates, for instance, he quits and goes to work for somebody else, and after leaving General Dynamics, he files his claim for those earlier medical services, what happens to that claim?

A. Those claims would be honored because they were incurred while he was insured under our plan, or while he had the plan benefits as a covered member.

[117] Q. And the incurral is the result of the service being rendered?

A. Rendered during that period of time he was covered.

Q. And if a medical service is rendered to a dependent who is covered by a General Dynamics plan, and the dependent then loses his coverage under the plan, and the claim for those benefits is submitted after that, what happens to that claim?

A. For those expenses that are incurred during that period of time in which that person was a family member, they are honored under the plan.

Q. If General Dynamics terminates its medical benefit plan, what happens to claims for services which were received by the employees prior to the termination of the plan?

A. Those benefits have to be honored. That period of time, you are talking about run-off claims. We are liable to honor those claims as if the coverage was continuing.

Q. Because?

A. Because the plan was continued at that time the expense was incurred by a covered member.

Q. Does the handling of medical benefit claims result in disputes with covered employees?

A. No.

Q. Why aren't there disputes with covered employees?

A. When we deny a claim, we must be very specific as to what reason, or what exclusion generally, we are using. [118] We indicate on our explanation of benefit payment form, the reason directly to the employee, and it references the instructions, exclusions, definitions, limitations, that are described in the brochure that he received from the policy holder.

Q. What is the incidence of lawsuits regarding medical benefit claims?

A. Very rare.

THE WITNESS: Your Honor, I have additional factors here, if you would like.

THE COURT: What was 229 out of 33 million? What was that? Wasn't that the same question?

THE WITNESS: That was particularly on prevailing fee suits—prevailing fees.

THE COURT: And opposed to—what is this?

MS. McNOWN: Suits, in general, about medical benefit claims.

THE WITNESS: Other than prevailing.

THE COURT: For example?

THE WITNESS: For example, that we denied a claim because it was a cosmetic procedure. And cosmetic procedures are excluded across the board for the plan. And, yet, let's take for instance—a very—the case I'm going, where a child was born without a left ear, and because he was entering school, because of psychological reasons the father wanted [119] coverage, and asked us to pay bene-

fits. Now, I would want my child to have a plastic ear so he would not be ridiculed. So in that particular case, there was no accident, and there was no functional improvement. It was cosmetic, and specifically excluded under the plan. Now this is a very obvious case where you have a contract on one hand, and sympathy on the other. But this is a typical type of claim that the Aetna would have to be involved in, in defending our position and its contract.

THE COURT: Okay. And the 229 cases you talked about were?

THE WITNESS: Only on prevailing fees.

THE COURT: Okay. On the amount paid?

THE WITNESS: Yes, that is correct. On surgery, there was always surgery to it.

THE COURT: Okay.

THE WITNESS: These other cases are cases like the cosmetic surgery. In 1979, we had 16,000,000 drafts. Sixteen million claims, and 129 lawsuits.

By Ms. McNown:

Q. And this was for a medical benefit claims?

A. That is for everything, medical, disability, health and dental. And in 1982 we had 33,000,000, and we had 199. In those years—

Q. Okay. You said 33 million what?

[120] A. 33,000,000 claims were paid in 1982.

Q. And how many . . .

A. 199 lawsuits.

MS. McNOWN: May I have one minute, Your Honor?

THE COURT: Yes.

MS. McNOWN: That's all I have on direct examination, Your Honor.

THE COURT: All right. We'll take a ten minute recess and then we'll start with the cross. We now stand at recess for ten minutes.

(Whereupon, a short recess was taken.)

THE COURT: (Back on the record.) You may be seated. Defendant may start with its cross examination.

MR. JOHNSON: Thank you, Your Honor.

CROSS EXAMINATION

By Mr. Johnson:

Q. Would you have any instances where a worker would file a form seeking reimbursement, and as a result of his filing a form, be reimbursed less than what he sought on his form?

A. Yes.

Q. Why would that happen?

A. There are many instances; for instance, I personally believe that every employee in the United States firmly believes that its play will pay 100% of any expense he is going [121] to receive. Our job is to receive those bills and to process it in accordance with the precepts of the plan, the basic and the major medical; and explain—and by showing the payment, exactly how we handled it. And that probably, in more time than not, is the first time that an employee really becomes aware of what is available under his plan. So, for instance, if that employee expected full reimbursement for some surgery back then, and yet we had a scheduled benefit, we would be showing him that we would be paying less than what he had anticipated.

If he were unaware that we were paying on an incurred claim, and he incurred it prior to the effective date of coverage, he may be surprised to learn that the coverage is only effected for expenses incurred on and after the effective date of the plan.

If it was workmen's compensation, our job would be to politely say that nothing is available here, but it's available under another plan which is diametrically opposed to group insurance. In other words, if it's workmen's compensation, it's not group. And if it is group, it's not workmen's compensation. It is either/or.

So all of this is part of the routine screening process that the processor has to account for, and in line with the ex-

clusions that are right in the plan, if the doctors charge was the highest fee in St. Louis, we would have to tell [122] the employee what we are paying under basic, what we accepted under major medical as a prevailing fee, and the balance is just not covered by the plan.

So, in each one of those instances he would be using our explanation of benefit payment form, as news that is different than he anticipated.

Q. Was that rare that the worker would receive less than they sought in their form?

A. That would be difficult to determine. I don't know what you would use. For instance, if you'd use as a guide, how many times did the claim office receive a telephone call, then I would say that 25% of the time you would have a telephone call to our office saying "How come you only paid $400, where the doctor charged $500?" And, again, what that is, is a reiteration of our explanation in the first place. And sometimes the brochure or the plan description that was given to them when they were first employed, might have been lost or misplaced, and we would direct them saying, "Well, don't you have a copy of the brochure? Do you see that this is all that we can allow?" And, if they didn't, we'd ask them to go back to personnel and get a copy. Because all we were doing is handling their claims for them. we were computing it and we were doing it in their favor, as an agent for General Dynamics.

THE COURT: Defendant, would you speak up, please? [123] The Court is having a little trouble hearing your questions.

MR. JOHNSON: Yes, all right.

By Mr. Johnson:

Q. Would you have instances where the worker filed a form seeking reimbursement and received zero?

A. Yes, again, if they misinterpreted what was available. The quickest thing that comes to my mind is workmen's compensation. If they sent that to the group plan

for reimbursement, we would be returning it to them, saying, "Look, you just mailed this to the wrong place. It goes to the workmen's compensation area." It's a rare—

Q. Where else might that happen?

A. Pardon?

Q. Where else might that happen?

A. It's a rare instance, because really it's just a misdirected piece of mail. The effective date of coverage being subsequent to the date that a claim occurred, is more frequent than a workmen's compensation denial. But, then, again, you're only talking about the new employees that a company might have. But, if you compared all of the claims that we received, to those claims we paid zero, you wouldn't have a percentage, it would be really the exception.

Q. Once you had a worker who received medical treatment, when would you know whether what he had received was allowable under the plans?

[124] A. Okay. As we looked at the claim, we would be able to make a determination because of the description of the plan that was given to our processors, and our understanding of the contract, we would make a determination at that point.

Q. Then you would need to have a filed form and have some information along with that form?

A. Well, we need the information. Now, theoretically you could have gotten it at the time of the accident, if we were a witness, but the majority of the time, we're getting it with the daily mail. He's reporting to us "I've got these bills. Please process them for me."

A. And so he sends that in with his form?

A. That's correct.

Q. What would happen if the worker filed no form?

A. If he filed no form—now, remember in our description of how we processed claims—the form has got

to come from General Dynamics because it is on that form that we know that his man belongs to General Dynamics. Otherwise, it could be coming from anybody in the world and we wouldn't know which company or which plan to associate this with. But assuming that it is through General Dynamics, the claim is presented to us, and we are able to determine who he is, and what benefits are available at that time.

Q. And you are the ones who are mailing out reimbursements?

[125] A. That's correct. At the field office. And our claims offices would be paying the claims, yes.

Q. And the first word that you would have is when you receive the form?

A. That's right.

Q. You were mentioning earlier about what would happen if you had a—let's say you were at the hospital at the time the worker received his treatment. Would you make the worker file a form at that time?

A. I understood that to be by way of example. In today, at the Aetna, we actually are paying claims at the date of discharge because of a cooperative effort by computer, so that the information is entered by computer at the hospital. Now, are you saying—

Q. How about back in '72?

A. Back in '72 we would be first aware of a hospitalization, at the time of discharge, at the time that the hospital would have mailed the form, or the supporting claim form to us. Because, remember, before the hospitalization occurs, generally, General Dynamics would have completed a hospital form, guaranteeing to the hospital that this person is covered under the plan, and the hospital would allow them to gain admission to the hospital, in lieu of some other financial arrangement. So,

once that came to us, the coverage would have been certified already, and with [126] the itemized bill, we could make the determination.

Q. You mentioned earlier what would happen if you had the processor right at the hospital.

A. Yes.

Q. Would the processor look at the form, and the information with that form, at the hospital?

A. Correct. Yes.

Q. But the form and information was usually mailed in later?

A. That's correct.

Q. But that form and the information was—or, you had to look at that form and the information, and without that form, and without that information, you would not act on it?

A. We would not know that there was a claim.

MR. JOHNSON: That's all the questions I have.

THE COURT: All right. Redirect?

MS. McNOWN: Could I have one minute, Your Honor?

THE COURT: Yes.

REDIRECT EXAMINATION

By Ms. McNown:

Q. Mr. Loftus, when an employee submits his claim form for reimbursement for medical benefits, has he already, himself, calculated according to the terms of his plan, the benefits that are due and owing to him, and then provide [127] Aetna with that calcluation?

A. Well, why, of course, we don't require that. I would imagine that most people mailing a claim to us have some idea of what they would expect from us, because again, we have the brochure being available from the employer.

Q. But does the employee do the calculation in order to submit his claim to Aetna?

A. No.

Q. Aetna does the calculation for the employee?

A. Yes, on his behalf, that is correct.

Q. The employee submits all of his bills and information pertaining to a particular receipts of medical services, to Aetna. Is that correct?

A. That's correct.

Q. And Aetna uses all that material to make a calculation of the benefit for that employee?

A. Yes.

Q. When—

THE COURT: The Court will remind you, you are on direct, and you are using leading questions, and you should be not using leading questions at this time.

MS. McNOWN: Okay.

By Ms. McNown:

Q. Mr. Loftus, if a processor is at the hospital, would you tell us whether or not at that day, the facts that [128] are necessary to calculate the benefits are in existence?

A. They would be in existence.

MS. McNOWN: No further questions, Your Honor.

THE COURT: All right. Recross?

MR. JOHNSON: Thank you, Your Honor.

RECROSS EXAMINATION

By Mr. Johnson:

Q. Let me ask you about your last answer; you mentioned that the facts that you would need were there at the hospital, at the time the services were rendered?

A. Could be. Could be, and might be there.

Q. They might be there?

A. Yes.

Q. Would you need to actually look at those facts and to analyze them, before you would first make reimbursement?

A. Yes.

THE COURT: Is that it?

MR. JOHNSON: That's all I have, Your Honor. Thank you.

THE COURT: All right. If there are no further questions of this witness, this concludes the testimony of James Loftus. Thank you, very much, Mr. Loftus, for your testimony in this matter.

* * *

PLAINTIFF'S EXHIBIT 47,
DEPOSITION TESTIMONY OF C. ROBERT SCHALL

C. ROBERT SCHALL, called as a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

By Ms. McNown:

Q. Mr. Schaal, would you please state your name for the record?

A. C. Robert Schaal.

Q. What is your address?

A. 237 VanBuren Street, Lyndhurst, L-y-n-d-h-u-r-s-t, New Jersey 07071.

Q. Okay. By whom are you employed?

A. Prudential Insurance Company.

Q. When did you join Prudential?

A. In March of 1954.

Q. What is your current position with Prudential?

A. I am manager and senior claim consultant of the group health claim administration division.

Q. And what are the duties in your current position?

A. Prudential has in our eastern home office [5] approximately—they have nine claim divisions, mine being one of the nine. My division is unique inasmuch as the balance of the claim divisions process claims for our policyholders. In other words, they make the payment, they being Prudential, whereas my division is made up of clients who pay their own health claims. They have either a Prudential draft book or their own checkbook and they do their own processing, and my division supplies claim advice to these clients to be sue that they are paying in accordance with their policy provisions and with the current medical technology today that is known.

Q. How large is the staff in your division?

A. I have 30 people.

Q. How many clients or customers are assigned to your division?

A. I would have 90 clients in my division.

Q. Are these clients insured, uninsured, both, mixed?

A. There is a mix of everything.

Q. What specifically does your division do in working on the client cases that are assigned to it?

A. There is two major breakdowns, one being [6] supplying advice to these clients on referrals that the policyholder would be sending into us or clients would be sending into us. We provide them with authority guidelines of dollars amounts and types of claims that they can be processing. If something falls outsides the scope, they send it into us, or if they come against any problem that they are not aware of or know how to handle, it is referred to Prudential.

The other avenue is that we have people that would go out to these clients and conduct periodic claim surveys again to see that claims are paid in accordance with the

policy provisions. There is documentation of the billings to substantiate the amounts that are paid.

Q. When a new client comes to your division, does your staff get involved with any activities at that point?

A. When we receive what we term as underwriting briefs, which is the documentation of the plan from our underwriters, we then prepare instruction manuals. We then go out to the policyholder and instruct them on the level of benefits, how to handle the claims and offer our [7] services, as I say, as a consultant.

Q. Now, you referred to policyholder in that answer. Are you referring to just insured cases or to—

A. No. Policyholder, client, we use the term synonymous. I guess I should just refer to it as client.

Q. So when you make that reference, you are referring both to insured medical benefit plans and uninsured medical benefit plans?

A. That's right.

Q. Okay. What positions have you had previously with Prudential since you joined Prudential, and briefly what were your duties in those positions?

A. In 1960 I started in the claim division. I was a claim examiner going to an intensified training program, and, as I said, worked as a claim examiner processing claims. And then as we advance and get experienced you move into other levels of authority, of greater authority, and move to different titles of claim approver, assistant claim consultant, claim consultant, group claim manager, which is the field position, and then to my current [8] position as a manager and senior claim consultant. And each level, as I mentioned, has a different degree of authority, responsibility based on a person's experience.

Q. Okay. I believe you started explaining your duties in 1960. Did you positions with Prudential prior to 1960 involve medical claims processing?

A. It was basically a group insurance in the actuarial department working on dividend calculations and pension area items of that nature.

Q. Okay. So how long have you have been working in the health claim area?

A. Since 1960.

Q. 23 years?

A. 23 years.

Q. In your work in the health claim area have you observed and become familiar with how Prudential itself handles health claims?

A. Yes. I mentioned before in coming though the ranks, so to speak, from claim examiner doing field work with our clients and conducting the claim surveys, again, that I referred to before, so not only do you know what we do in-house, but what our [9] clients do in performing their claim functions.

Q. Okay. In observing the processing of health claims has that included observing the processing of insured health claims?

A. Yes.

Q. Has it included the processing of self-insured health claims?

A. Yes.

Q. Now, we referred to health care claims and medical benefifts. Would you tell us in general what is meant by health care medical benefits?

A. There is two groupings, categories that we can place them into; one being a basic coverage, that being a hospital, surgical, x-ray and lab, and there is other fringe benefits that are also classified as basic benefits, and then you get into the other major category and that being a major medical type expense.

Q. What is covered by major medical?

A. Major medical you would pick up any excess that would be considered eligible for many of the basic coverages that the base plan did not pay, and also items that are not covered under base plan, for example, drugs, office visits, any other routine [10] medical care. There are some supplies that would also be: wheelchairs, rental of equipment, purchase of durable equipment would also be covered under major medical.

(WHEREUPON, discussion was has off the record.)

By Ms. McNown:

Q. Okay. Have you had occasion to work on General Dynamics' and its affiliated corporation's health claims?

A. I first started working on the General Dynamics account in 1969 when I was assigned as the group claim manager that is conducting field surveys.

Q. And which facility or facilities did you work with at that time?

A. At that time I worked with the Electric Boat Division in Groton, Connecticut, in the Electro Dynamics Division in Effingham, and I also had exposure to, while not having direct responsibility for, claims surveys of the Quincy location, and then later when Quonset Pointe, Rhode Island location came aboard I serviced that account also.

Q. Would you describe what kind of work you have performed in connection with the General [11] Dynamics account in the health care benefit area?

A. Well, aside from conducting the claim surveys that I referenced before – in conducting a claim survey I guess I should mention that we work off of a health payment listing. This is a listing of payments that have cleared through our accounting system. We use this as the base to go on and conduct the survey to select the claim files and to review again the documentation, the bills to make sure

that they are in accordance with the policy provisions and the level of benefits that are paid is in accordance with the plan requirements.

Aside from that we—as the case requires it, we would be involved—I would be involved with claim training also.

Q. What do you mean by claim training?

A. If the facility had a loss of one of their claim examiners and they would hire a new person, they would be supplied with material to read, and then I would come on the scene and go over the detailed claim work with them as far as how to handle the processing of a claim. The local supervisor on site would then take up the person's development and review all of their claim work that [12] they would be doing, and periodically when I would go back to do another survey, I would concentrate then on that individual's claims that they had processed.

Q. Okay. How many times a year would you conduct a claims survey at a G.D. facility such as Electric Boat?

A. Electric Boat is done three times a year.

Q. And when you go out and conduct a survey, what period of time does each survey take?

A. Electric Boat takes four days. This would be a combination of all of the coverages of Electric Boat.

Q. Okay. When a survey was conducted at Electric Boat what quantity of files or claims would be involved in a claims survey review?

A. Again, basically it would be working off this health payment listing and pulling the claim files, looking at the various payments. There would be several hundred payments would be reviewed in detail to compare against this listing.

Q. Okay. Were there any other services that you performed on the General Dynamics' account in addition to claims surveys and assistance on [13] training personnel?

A. I was involved with the local medical society, attended several meetings, also visited local hospitals in the

area, worked with the plant physician at Electric Boat in the administration of the overall plan.

Q. You provide consulting work in all areas of the plan?

A. Yes. We prepare statistical reports also that would periodically be reviewed with the client as to the number of hospital claims, the physician involved, durations of various diagnoses, things of that nature.

Q. In 1969 was General Dynamics insured or self-insured for its employee health benefits?

A. They were insured.

Q. And it has been stipulated in the case that that change from insurance to self-insurance was in 1972.

Did you survey General Dynamics' claims while it was insured?

A. Yes.

Q. And for what period?

A. From 1969 to 1972, the date they turned [14] over.

Q. When they changed to self-insurance did you continue to survey medical claims at the Electric Boat facility?

A. I continued to conduct surveys from '72 through '75 when I was promoted to my current position.

Q. From your survey work at Electric Boat and other General Dynamics' facilities would you tell us whether or not you had an occasion to observe how the General Dynamics' personnel processed medical benefits claims?

A. Yes, by—you have to know from the time a claim was received through the particular handling of the claim to the drawing of the instrument and payment and how it is released, so I would know all aspects of the on-site handling of a claim.

Q. Would you describe the qualifications and training of the General Dynamics' personnel who processed medical benefit claims?

A. I believe that the people at Groton are extremely experienced and have a stable force up there and thus have quite an experienced force. So the amount of training on this particulary—for [15] this particular client has been minimal compared to other clients, so they have a very experienced staff.

Q. When General Dynamics changed from insurance to self-insurance for the health benefits, in what respect, if any, did the claims processing procedures for medical benefits change?

A. The only real noticeable change is in the payment of the instrument; the instrument being a General Dynamics checks rather than a Prudential draft. The physical payment would be the only—the claim handling woud remain the same.

Q. All right. I would like to now go through how a medical care benefit claim is processed, and I'd like to start in the period 1972 after General Dynamics changed to self-insurance. What happens first?

A. Well, upon receipt of a claim form and properly itemized bills, which could either be walked into the benefits area or mailed in—

Q. When you say, "Walked in," what do you mean?

A. The employee could walk into the area, just drop it off.

Q. Okay.

[16] A. Or it could be mailed in. It could be received from a hospital or another provider, but the claim would be received and clerical person would then conduct a review of eligibility by turning to the enrollment records. When the person was hired, they would enroll for the plan of benefits and they would check to see the employee's eligibility date and the—any names of dependent and dependent status on the enrollment record.

Q. Now, when you say, "Eligibility of the employee or dependent," what are you referring to?

A. That the employee has elected to participate in the General Dynamics' health benefit program.

Q. Okay. Once that check has been made, what happens next?

A. The claim then is turned over with the effective date shown on the claim form. It was turned over to a claim processor, and they would then put it with their work and they would handle claims in date order. And when that particular claim came up for processing, they would review the claim form in detail, which is very important step of the examining function, noting various questions [17] on the form both from the employee and also from the provider of the service on the reverse side of the form.

Q. Now, when you say, "Provider of the service," who are you referring to?

A. In most cases the provider would be a physician that would be rendering a service, whether it be surgery or medical care.

Q. Okay. Would a hospital be a provider?

A. A hospital is also a provider. Hospitals would be supplied with a hospital admission form, which is a certification again to the hospitals for a guarantee of payment that this individual is covered, and upon receipt the doors are opened to the hospital and they are allowed in. Upon discharge an itemized bill was usually attached to this form and then mailed to General Dynamics' location.

Q. Is what you just described on the certification to a hospital sort of a pre-clearance of coverage or benefits?

A. It is a standard procedure that has been adopted through the insurance industry with the hospitals that then they can—a person can get [18] in without putting money up front.

Q. Okay. Once—I think I interrupted you in your answer on the processing of the claim once it got to the processor.

A. After a thorough review of the claim form itself and any itemized bills that might be attached, they then turn to set up what we call a top sheet or a worksheet, terms are synonymous, which would display the type of surgery—excuse me, the type of service that is rendered. In other words, it would show the name of the hospital, the name of the physicians. Whatever bills would be attached to that claim form would be displayed in one column, as well as the dates that the service was rendered. The next column would show the appropriate charges that were incurred.

There are several other columns looking or visualizing it going across on a form that would—you would carry over these dollar amounts into the appropriate columns, depending upon they type of service and the level of benefit. For example, a hospital claim would be carried over to the hundred percent column and room and board and ancillary charges would be totaled up, and depending on the [19] amount of the plan, at that point would be shown in the hundred percent area. The excess would be brought over into the last column, which would be major medical column, which would be subject to a deductible and coinsurance, and each category is shown on this top sheet and you just segment each piece and handle each one.

You look at each bill knowing where each one would fall and just carry it across on the top sheet, and then you just summarize and total up your expenses and you can cross foot. This is also used—is mailed out with the payment so that the insured or the claimant would be able to see how their expenses were handled, each particular item. So it is an explanation of the benefits of how they were paid.

Q. Okay. So this sheet is sent to each claimant?

A. That's right, as well as a copy is kept in a claim file, which would allow us to conduct our claims surveys, also.

Q. You mentioned co-insurance when you were discussing major medical. What do you mean by co-insurance?

[20] A. Co-insurance would be applied to an expense, and, again, depending on the type of expense you have different co-insurance amounts, the most common being an 80/20 percent ratio. It could be 75/25, or for some specific type services such as psychiatric it could be a 50 percent co-insurance benefit.

Q. When you say 80 percent, 20 percent—

A. 80 percent would be paid by the plan and 20 percent by the claimant.

Q. So the plan pays part of those expenses and the employee pays part of those expenses?

A. Depending on the type of expenses, that's correct.

Q. Okay. What tools does the claim processor have in order to be able to make the calculation of basic medical benefits?

A. Well, as part of the material that we call tools of the trade that would be supplied to each one of our clients we provide them with a directory of hospital facilities so that they would check on the eligibility of the institution. We have supplied them with a surgical schedule or schedules, as the case might be, for the various plans in force [21] that would enumerate the procedure, procedure code, and the dollar amount of the surgical benefit for that particular code and procedure performed. This surgical schedule runs in the neighborhood of 70 plus pages. It is a very comprehensive schedule, and any procedure that might not be listed they are instructed to send into Prudential for advice.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Okay. You referred there to procedures. Are you referring to operations?

A. Yes, surgical procedures.

Q. Okay. Like an appendectomy or a tonsillectomy?

A. That's right. Tonsillectomy, delivery, paternity, obstetrical care.

Q. Okay. Are there any additional tools that the examiner or claim processor has in order to calculate the major medical benefits?

A. One item of particular importance that we supply them with is an eligible/ineligible guide which lists various durable equipment purchases and rental that they may see on a particular claim. It [22] lists, not only those that are acceptable, but those that are not acceptable. They either accept some or conditionally depending upon the condition involved for the person. There is a code on there to indicate whether it is acceptable across the board or just for a particular condition.

Q. Okay. Anything else that the examiners have as tools in order to calculate the benefits on a medical benefit claim?

A. Well, of course, they would have a description sheet outlining the level of benefits for that particular plan so they would know the dollar amount of benefit for a surgical procedure, for hospital room and board or semi-private room rate or whatever the plan might call for, what level under that particular code.

Each of the General Dynamics locations and plans have a—what we call a branch code, and that is identifiable to the plan of benefits both surgery and also the hospital. For example, some plans might call for $60 a day room and board, some might call for 65, some 70, and they keep, of course, over the course of time changing and increasing as negotiations develop.

[23] Q. So the processor has the current benefits provided by the plan?

A. That's correct.

Q. Once the calculations have been completed on a claim, what happens next to that claim?

A. Like I say, the total are all brought down and calculated and cross foot. We have some statistical coding that appears on the bottom to indicate the type of benefit, hospital, surgical for our reports that a health payment listing I mentioned before is produced off of and it goes to an area where the payment instrument would then be drawn and signed along with this work sheet, top sheet. They would be mailed out to the claimant or if benefits were assigned, a copy would go out, or that part of it would go out to the provider of service, the hospital, physician, if benefits were assigned, and the employee at all times gets a copy of the work sheet.

Q. Okay. So there are direct payments at times to the hospitals and doctors?

A. To accommodate the employee in assigning—if he assigns benefits.

Q. All right. The claims processing that we [24] have gone through sounds like a fairly simple claim. What happens to claims that are not that simple, that have some complicating or additional features?

A. Any plan that falls outside of the guideline that I mentioned before that is supplied to them or any question that they might have, it doesn't have to fall outside the guideline, is sent into my staff and it would be reviewed and a decision then would be made and sent back to the location giving them the direction on how to handle the claim.

Q. So Prudential provides consulting for certain claims that are referred to them by the General Dynamics' facility?

A. I think we can say those claims that fall outside of the routine processing.

Q. What percentage of claims get referred to Prudential?

A. Our normal book of business is—I guess the way I can explain this based on a division and staffing would represent between 90/95 percent of claims are handled routinely.

Q. Does that mean that Prudential does get referrals on those 90 to 95 or do not?

A. We would get referrals on the 5 to 10 [25] percent. I would also say though, as I had mentioned before, that due to General Dynamics' experienced staff that they have been fortunate in having over the years that their referral rate would even be reduced. I would say theirs would be closer to 95 percent. We would only be seeing 5 percent of the claims, if that even.

Q. Prudential would only be seeing 5 percent of the claims?

A. That's correct. Prudential would only see.

Q. Who at Prudential provides the consultation on these roughly 5 percent of claims that get referred into it for review?

A. Well, I have experienced staff in my division and the people that I have are—again, compared to the other divisions that I referred to before—are more experienced because we are actually receiving referrals from clients who have experienced staff out there, and our people would have to know how to handle the more difficult or involved claims, so these claims would be coming into experienced staff within my division. And also within the division we have level, again, of authority and involvement depending on the type and [26] the nature of the situation, and possibly would even come up to me for final resolution.

Q. Does your division have any support facilities from Prudential that are outside of your division or does your division do everything?

A. No. The division has several support areas, some are outside of our physical area, but one—we have a physician that is on-site. In fact, he is physically located in my division even that we would go to and either refer via a form with the claim documents or go and speak with him, sit down and discuss the particular situation at hand with him.

Or the other area would be our legal staff, which we would refer any legal questions to that might involve state laws or requirements, and we would send it to our law department, and, again, there are attorneys there that work on just our group book of business, and they would return it to us and we then would advise our clients. And in-house we also have, of course, our own underwriters that we would go to for any statistical information that might be necessary. Copies of the contract, things of this nature would all be there [27] so we could have that accessible to us.

Q. Okay. You stated that the staff in your division are experienced. Is there any general level of experience that those people have?

A. From a time standpoint?

Q. From a time standpoint.

A. Most of them would be, I'd say, between 10 and 15 years with us.

Q. Processing medical claims?

A. They would have prior experience in processing the claims, and that is how I pick my people from the other divisions. After the people have gained the experience in processing claims, then they come into my division, so that is why they are—have more seniority than what you will find in the other processing division.

Q. Okay. Do the General Dynamics' medical benefit plans have any items or categories of charges which are excluded from coverage?

A. Yes.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Do the General Dynamics' plans pay for [28] items which are not reasonably necessary for medical care of sickness or injury?

A. No. It is one of the excluded items in the policy.

Q. How does an examiner or a claim processor determine whether or not a charge is reasonably necessary for care of a sickness or injury?

A. The examiner would have, again, the parameters of the guidelines that we provide. They would gather the information pertinent to that particular item or service that was rendered, send the facts into us or call us. We try to expedite it first over the phone. In most cases, though, if it is getting into any kind of a technical nature, we will request that the file be sent into us, and then we would review the facts that are presented and again with other—our medical or law department is a type of question at hand, it would then be resolved.

Q. Okay. Does an examiner, say, at Electric Boat use any of the tools that have been provided to them to determine whether or not charges are reasonably necessary for specific types of care?

A. Yes. They would have again [29] eligible/ineligible guide, past experience. When we refer claims back that they might have, they could very well come across another plan that we were paralleling, a prior claim that was referred to us with all the facts, and then they would use that. They have their own library that they would set up and establish on referrals into us.

Q. Okay. Do the—

A. Experience is one of the big items here to know.

Q. Would the examiners at Electric Boat be able to determine that various charges were reasonably necessary for care without referring those questions on to Prudential?

A. They would definitely know if something fell out of the norm and that it should be referred into us. In the

training what we try to get across to everybody is that certain claims a bell will ring, and that is the time that you have to look forward to going further with the particular claim. Most of the claims, as I have indicated before, are routine claims. It is those claims, those exceptional claims that you will come across occasionally that will require some different type of handling and [30] maybe have not had the exposure, but we train them to identify those problems so that would trigger off this bell that I referred to and get it going into Prudential.

Q. When a claim is sent into Prudential for review on the issue of whether a charge is reasonably necessary for care, how does your staff person make a determination on that issue?

A. Usually we would have the background information from the provider of service citing the reason why he did render whatever services in question. It would then be reviewed by our laypeople, my staff, and they would consult with our in-house physicians to determine how the medical world reviews this particular item that is in question.

Q. If the medical world regards it as usually necessary, what happens?

A. It would filter back to our office and we would indicate on the referral that this item is acceptable and send it back to the location and they would process the claim.

Q. If it is determined that it is not generally accepted by the medical profession as a treatment, what happens to that kind of claim?

[31] A. We then provide the location again with the reasons so that they could incorporate it in a letter. Usually if we are knocking something out of any consequence we would have it done by a letter informing them of the reasons and the position of why it was not accepted, and also in the event there was someway that they could advise them to make the claim whole to what we would need for further review, if that was the case.

Q. When you say "Make the claim whole," what are you referring to?

A. If there should be some particular item that based on what we have submitted here in our decision and how the decision was arrived at is not, let's say, in the proper vein of what the provider meant it to be, how he expressed it or what the information that we have, it could be off on another tangent, he would then send it back and that would be making the claim whole or correcting the information. Any clarification of the details, in other words.

Q. You are talking about providing additional information?

A. Additional information, right. If any [32] additional information is available.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Okay. And if additional information on a claim is submitted, is that considered by the processor in arriving at a final resolution on the claim?

A. It would depend on the complexity of the problem at hand. If the processor felt that the information received was clear and allowed them to pay it, then they would just process the claim or they would get this additional information and pass it on to us. We could either at that point stop and say we are in agreement with it and have it—return it to the location, or we could go to our medical department and consult with them on it and they in turn, depending on what they come back with, it would be again back through the ranks again.

Q. But this additional information is considered by the processors?

A. Definitely. And every time a referral comes in or request for review of a referral or prior decision, it is always reviewed at a higher [33] level than the one previously.

Q. When charges come in at the field office do the examiners there use this list you referred to of eligible charges/ineligible charges to make determinations that—

A. Yes.

Q. (Continuing)—items are covered by the plan or not covered by the plan?

A. Yes.

Q. Does the General Dynamics' medical benefits plan cover charges for services or supplies which are excessive?

A. No.

Q. How does an examiner determine whether charges for services or supplies are excessive or not?

A. Services with reference to surgery, they are provided with a file which would show by geographical area the 90th percentile for a particular procedure in a geographical region. They would look up this profile that is made available to them to see and compare it against the fee that the provider has rendered to see whether it is less than or equal to the amount. If it is less than the [34] amount or equal to the amount, then the claim is processed. If it exceeds that amount, there is criteria that they would have as far as what information would then be requested, the most common being an operative report.

Q. Why would you be requesting information if it is higher than the 90th percentile?

A. Well, to see if there is any additional information. We are working with an itemized bill for a claim form which the physician or a secretary is completing it might have been very brief in giving a description of the surgery. However, if you get into the operative report there might have been adhesions or other complications, and that would then warrant additional dollar amount of benefits that might be considered and the fee may well be within the acceptable limit then.

(WHEREUPON, discusson was had off the record.)

By Ms. McNown:

Q. You referred to the processors having a surgical profile which shows the 90th percentile of surgical fees for

procedures. Would you explain what you mean by 90th percentile? I think it may be [35] clear to you, but not too clear to us.

A. Over the course of time and periodically updated we gather statistical data on various surgical procedures which are coded by the procedure and there is values applied to it and with the dollar amounts and you arrive at an amount that would be considered reasonable and customary, again, doing a mathematical formula of calculating a 90th percentile. It is a mathematical formula is what it is.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. When you say, "We collect information," who are you referring to?

A. Prudential computer system.

Q. Okay. Is it correct that when this mathematical formula is applied to the 90th percentile means that 90 percent of the fees for that procedure are—

A. In that given area would be acceptable.

Q. (Continuing)—are at or below that level?

A. That's correct. That's correct.

Q. Okay. So the 90th percentile approves 90 [36] percent of the fees in an area for a particular procedure?

A. At least 90 percent. It could be even a greater percentage depending on the array of charges.

Q. Okay.

A. And again it is a mathematical formula depending on the number of claims in it. You have to have ten or more claims in order to come up with the 90, but, again, depending on the array of charges it could be accepting more than that.

Q. Okay.

A. And this is used, not only by General Dynamics—or it is used by Prudential on all of our accounts and all of our clients that process their own claims.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. Does the General Dynamics' medical benefit plan exclude in coverage preexisting conditions?

A. Yes, it has a preexisting exclusion.

Q. How does a claim processor determine whether or not there is a preexisting condition?

A. The initial review of the claim form would [37] be the first and really the only key to look at to see the type of illness or injury, to see the onset of the service, which is one of the questions on the reverse side of the claim form, and if it was an accident, the time and date of how soon prior to or around the effective date of the plan the condition commenced or the prior service was rendered.

In other words, if you looked at a condition, let's take a cancer situation, and somebody came to work two weeks ago for you. After the effective date—let's say you have a three-month waiting period, and then two months after that you would get a claim in and it showed as a diagnosis cancer. This would, of course, cause rise to suspect that when was—or at least raise inquiry as to when was the onset of this cancer. It could very well be within that three-month period, but assuming it was prior to the effective date this would be something you look at.

If it was an accident, on the other hand, somebody fell of a bicycle or while they were jogging they fell, then that would be something that would happen at that point in time and that would not be pursued at all.

[38] Q. Okay. If the condition for which the charge was rendered is of the type that could be preexisting, how does the claim processor know whether or not to exclude it from coverage or to include it for coverage?

A. If there is a possibility that it would be something that might have incurred within the 90-day period, they would in most cases write to the provider of the service and ask that request with a letter.

Q. The provider being?

A. Whoever rendered the service that we had the bill for.

Q. Such as a doctor, or hospital?

A. Doctor in most cases it would be.

Q. And—

A. Doctor with the question, "Did you render a service within such a period of time for this condition?" and the doctor would sign it yes or no; he would date it and we ask for what charge because you have to have a charge. That is the key word here is that there was a charge incurred for this condition.

Q. In what period of time?

[39] A. Within the 90-day period prior to the effective date of the claim.

Q. If there was no charge for the condition within that 90-day period—

A. You could not invoke the provision then.

Q. (Continuing)—you would have to pay the claim?

A. Pay the claim.

Q. If there was a charge within the 90-day period?

A. It would be deferred until there is a period of 90 expense-free days or six months, whichever comes first.

Q. And in processing the claim you rely on the provider's statement of whether there were or were not charges in this period?

A. Yes. That is the only real source of document that you would have to go on.

Q. What happens if a claim is submitted without complete or adequate documentation?

A. Depending on the information that we are talking about, if a person left off the date of birth or something like that, we could look at the last claim in the file to see, if it was Social [40] Security number or something like this, if the individual failed to—

Q. If it was that kind of information what happens?

A. We process the claim then.

Q. Okay.

A. If it was something that the person did not answer the questions as far as a Worker's Comp or coordination of benefits, then we would ask that question. We would go back to them. Again depending on – Dynamics, I think, is unique also. They have – the benefits department has a good rapport with all of their people. They pick up the phone and try to contact the person and chances are they would get that question over the phone. Coordination question again could be checked out on a prior claim form, although there is a possibility that it could change from two months ago when they submitted the last claim, but that would not be a key item at that point.

Q. Okay. If a claim has been submitted without –

(WHEREUPON, discussion was had off the record.)

[41] MS. McNOWN: Strike that.

By Ms. McNown:

Q. If the claimant does not submit the doctor's bill or itemized charges, what does the processor do with that claim?

A. That part of the claim that is not whole, let's call it – if it is a bill – let's say five bills come in, one bill does not have an itemized bill, is not itemized, then the balance of the claim in most cases, 99 percent of them, would be processed, and that one bill would be then – on the worksheet we would ask for completely itemized bill or whatever is missing. It might be the diagnosis, it could be the date of the service, it could be the type of treatment that was rendered. Sometimes we get bills in just say, "Balance due" and that does – that is not acceptable.

Q. So you ask the claimant for the additional information?

A. We would ask the claimant for that and upon receipt of that then the balance of the claim would be paid.

Q. Do the General Dynamics' medical plans have any provision for coordination of benefits?

[42] A. Yes.

Q. Would you briefly explain what coordination of benefits is?

A. Coordination of benefits comes into play when two or more covering individuals have group insurance plans to cover the medical expenses that have been presented. It could coordinate to the point that would allow the individual to collect 100 percent of the allowable expenses, but would not allow them to collect 100 percent under both plans.

Q. Okay. You referred to two people having group health coverage. Are these persons family members related to each other?

A. Yes. It could be the husband and wife or spouse. It could be dependent children that might have a group coverage.

Q. How is coordination of benefits accomplished? How does that work?

A. Again, the initial review comes from reviewing the claim form, and there are a series of questions about is your spouse employed, or if it is on a dependent child, is that child covered and, if so, where, name and address, and then there is a series of questions on other group coverage and the [43] type of coverage and who the carrier might be or the provider of the benefit and any policy or control number.

Q. Okay. If there is information on a claim form that says there is other group medical insurance or coverage available, what does the processor do with the claim?

A. Well, one of the first things they would do would be to look at a prior claim. This way they may have been through it already on a prior claim which would allow them to determine if the plan is primary or secondary.

Q. When you say, "The plan," you are referring to whose plan?

A. The General Dynamics' plan or the other plan, as the case might be. There could be prior handling of this and it would be part of the file, and it would remain then and that would then allow them to process the claim at hand. If we were primary, for example–

Q. If General Dynamics was primary, what happens to it in the processing?

A. The claim would then be just paid.

Q. And by "primary" you mean what?

[44] A. That the insurance industry has guidelines and rules that are established to determine primary and secondary roles of the carriers or the plans in question. We go through the process of determining who the patient is and how the plans fall to determine who was primary, who was secondary.

Q. If General Dynamics is primary, does that mean it pays first?

A. That's correct.

Q. If it is secondary, does that mean it pays second?

A. That's correct.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. If General Dynamics' plan is secondary, how the claim get processed?

A. Again, if there is a phone message of who they contacted on a prior claim or if there was nothing in a prior claim, let's assume, they would then based on the information on the form as to where the other employer is, it could be a local employer, more than likely is a local employer, they would pick up the phone and call the benefits person [45] at the other employer and obtain the information as to what type of plan they had, the details and provisions and so that they could determine then who is primary and who is secondary. If that is not possible, it could be a local employer, but it is handled by another carrier, another state, let's assume, or someplace else, the industry has an

inquiry form that goes between the carriers to solicit the information as to who is primary, secondary, the provisions within each of the plans, and they also itemize the bills and what liability would be responsible for each one under the situation. So there is an exchange of information by the two carriers that would allow them to take their positions as primary or secondary.

Q. All right. If General Dynamics is secondary, how does that claim get processed?

A. Well, once it would be determined as to what the other carrier or the other carrier or the other plan paid, then we would calculate our normal liability and subtract what the other plan paid and then determine the amount that would make them whole up to a hundred percent. We would not pay any more than our normal liability.

[46] Q. Okay. Now, who established, if anyone established, the rules determining who is primary and who is secondary when there is dual or multiple group medical insurance coverage?

A. This came out of the health insurance industry itself through the HIAA, which is the Health Insurance Association of America, which is sort of the focal point of information to the industry.

Q. So—

A. And it was made by the carriers as a group with them.

Q. Are there multiple sets of rules or is there one set of rules?

A. No. There is one set of rules. I would like to just clarify that. There was one set of rules in 1972. Today they are starting to go on different tangents with divorced people, with females with children. Normally the rule would be to follow the male, and with different types of review of this particular provision, they are starting to look in different areas, but that has not been accepted or approved by all of the insurance departments and, therefore, not in

place [47] in every instance. So there are differences today, but back then in '72 and up to just the last year or so it was one set of rules.

Q. Can you briefly describe what those rules were back in '72 as to the order in which plans paid benefits?

A. Basically if you covered the patient and the spouse or the other dependent had coordination of benefits you were prime. If you covered the patient and the other plan did not have a coordination provision in it, then they were prime. Any plan that did not have it in was always prime first.

Q. Any plan without a coordination of benefits provision was always primary?

A. That's correct. When your plan had a coordination in it.

Q. Okay. If both plans had a coordination of benefits provision in it, then how did they sort out who was first and who was second?

A. By looking at who the patient was. If it was your employee, then the plan which covered the employee would be prime.

Q. Okay.

[48] A. When you get down to children, it is the plan that covers the father, the husband as the employee would be prime.

(WHEREUPON, discussion was had off the record.)

By Ms. McNown:

Q. If General Dynamics is the primary plan under coordination of benefits, does the existence of coordination of benefits substantially lengthen the processing time?

A. No.

Q. If General Dynamics' plan is secondary under coordination of benefits, does that substantially lengthen the processing time?

A. Not substantially. Depending on the availability of the information. Like I said before, it could very well be in

the file and there would be no time lost at all. If it was a phone call, it would be handled that same day. Then if the industry form went out—the industry is aware of the importance of making this mechanism work and we as an industry all agree to then reply to these inquiry forms.

Q. In the General Dynamics' plan is there any [49] time limit established for filing claims?

A. No.

Q. In processing the claims are there any rules about late claims?

A. No.

Q. You have mentioned facilities at General Dynamics for which General Dynamics' personnel processed the claims. Are there any facilities of General Dynamics for which Prudential itself processes the claims?

A. Yes. One of the largest one is the corporate office in Clayton, Missouri, where we would process the claims in another claim division in my office.

Q. Are there some other facilities?

A. Yes. The Electro Dynamics Division, some, I think, Stromberg units, but that would be it.

Q. What differences, if any, are there in the way that claims are processed under the medical plans where Prudential does the processing rather than General Dynamics?

A. The processing would be the same and the payment instrument is the same also with General Dynamics.

[50] Q. Mr. Schaal, are medical benefit claims denied until they are paid?

A. No.

Q. Did the General Dynamics' medical benefit plans provide that employees would be paid 100 percent of all of their medical expenses?

A. No. It depends on the level of benefit for the particular coverage that the service was rendered under.

Q. Under the terms of the General Dynamics' plans are all amounts that are submitted with the claims forms paid?

A. No.

Q. Why not?

A. Because they would—could fall out of the covered policy provisions; they could be in excess of the amount of what would be considered reasonable and customary, or they could be not medically necessary for the care and treatment of an illness.

Q. Under major medical does the plan also provide a provision for the employee to pay a given percentage of their medical expenses?

A. Yes. There would be a 20 percent or a—[51] could be a 50 percent in a psychiatric situation, as well as they would have the deductible corridor to take care of.

Q. Do the General Dynamics' plans cover Workmen's Compensation items?

A. No. It is one of the exclusions.

Q. How does an examiner determine that an expense is or is not excluded under Workmen's Compensation?

A. Well, we would start back with the claim form again. There is a question on the form for the claimant to answer of whether or not the expenses arose out of or in the course of employment. There is a question for the provider of the service, the physician, same type of question as well as the employer from their records of whether there was any report of any accident or compensation, Worker's Comp claim filed.

Q. So the examiner looks at that information to see whether it was Workmen's Compensation or not?

A. That's correct, as well as there is another question on a claim form for all accidents; they must be explained as to the type of accident, how it occurred, date and time, and if it was in the [52] normal workday, let's say, and the time was during the work hours, this would be suspect then to raise a question over whether or not this arose out of employment. It could be the person had that day off or something else, but it would just be something that would trigger perhaps a call to verify that.

Q. So if there was a question as to whether or not a claim was covered under Workmen's Compensation, the processor would call for more information?

A. Would call for more information. Again, we have other areas such as the provider or the hospital, the physician that might indicate also whether or not person goes to the individual and says, "Hey, I fell on the job. I did this, I did that on the job," and that is how he would answer that question, as well as the employer's record, as well as what the employee is alleging when he is filing the claiming. So there is three areas plus the question as far as any accident on the form, so there is four areas and you put them all together and develop the picture.

Q. Does the handling of the medical benefit claims under General Dynamics' self-insured medical [53] plans result in disputes with employees?

A. I wouldn't call them disputes whenever there might be misunderstanding or clarification would be required as to why or how a particular benefit was paid or what part of it was paid. So most cases the level of benefits that is paid might be in question.

Q. And is that explained to the employee?

A. It would be explained, but again sometimes they may not just understand the reason for excluding an item on that work sheet that I referred to.

Q. Okay. If after explanations have been given to employees who make inquiry about their plan of benefits, in your experience what is the incidence of lawsuits relating to the General Dynamics' medical care benefit plans?

A. Very minimal. I can recall two suits involving this client going back to '72; one I had personal knowledge with up at Electric Boat, that is how I know that one, and then there was another one at Quincy, I believe, but that was it.

Q. In all of the years that you have been working on the General Dynamics account?

[54] A. That's correct. That's correct.

Q. From your experience with Prudential what is the incidence of lawsuits over medical benefit payments?

A. I think when I look at the ratio of the number of payments that we made in 1982, we had over 450 million payments, and I checked the records of suits in our eastern home office that I work out of and we had 96 suits in 1982 and at the end of the year 46 of them had been resolved. There were 49 remaining open.

Q. So for your eastern office, is that—

A. That's correct.

Q. You had 450 million claim payments?

A. Payments, that's correct.

Q. And 96 lawsuits?

A. 96 lawsuits.

Q. In 1982?

A. In 1982.

Q. And this relates strictly to medical benefit claims?

A. That is medical claims or clients.

Q. Under the terms of the General Dynamics' medical benefit plan if a person incurs medical [55] bills prior to being an employee of General Dynamics and the person then becomes an employee and covered by the plan, if he submits those earlier bills to General Dynamics for payment, what happens?

A. They would be denied because the expense was incurred prior to the effective date of the plan.

Q. Prior to the date of the empoyee is a covered member under the plan?

A. That's right. Prior to his date of eligibility.

Q. Under the General Dynamics' medical benefit plans if an employee is covered by a plan and receives medical services which are covered by the plan and then he quits and after quitting he submits a claim for those earlier medical services, what happens to that claim?

A. That would be paid. That would be processed.

Q. Why would it be paid?

A. Because the expense was incurred while he was a covered individual.

Q. Under the General Dynamics' medical benefits plan if an individual is a covered dependent under the plan and receives covered [56] medical services at that time and later the dependent loses his covered status, he graduates from school or something, if the claim for those earlier services is submitted after he lost his covered status, what happens to those claims?

A. The claim would be paid again because the expenses were incurred during the period of time that he was a covered individual.

(WHEREUPON, a recess was had.)

By Ms. McNown:

Q. Mr. Schaal, does Prudential or General Dynamics claims processors have any general philosophy about claims handling?

A. For years we have always advocated that every claim should be paid in accordance with the policy provisions of the contract. We pay every penny that is payable and anything that is not payable is denied. We have a term in the business that we call the gray area, and if that gray area cannot be clarified, then the claim or bill in question is rendered in favor of the claimant, is paid then.

Several years back we committed to writing a Prudential philosophy on claim handling which has [57] been given to our internal staff, as well as to our clients processing their own claims, and that is the copy that we have here in front of us. While that has been published in 1975, I believe its principles and practice has been in effect pretty much from day one.

MS. McNOWN: Okay. Perhaps we ought to mark it since the witness has referred to it in his answer.

Would the reporter mark this as Schaal Deposition Exhibit No. 1?

(WHEREUPON, said document was marked Schaal Deposition Exhibit No. 1, for identification, as of 9/7/83.)

(WHEREUPON, the document was tendered to the witness.)

By Ms. McNown:

Q. I show you Mr. Schaal a document which has been marked as Schaal Deposition Exhibit 1 and ask if you can identify that.

A. Yes. That is the referred document, Prudential claim philosophy.

(WHEREUPON, discussion was had off the record.)

[58] MS. McNOWN: That is all my questions on direct.

(WHEREUPON, there was a short interruption.)

[59] MR. JOHNSON: I just have a very few questions.

CROSS-EXAMINATION

By Mr. Johnson:

Q. First, you mentioned that the worker would either walk in or mail in the form.

What would happen if no form was sent in?

A. If just a bill would be received?

Q. Or no information at all.

A. Okay. The employee then would be contacted to have either a claim form completed – I should go back and state that the first thing that would be done would be to look in the employee's file to see the last time a claim was submitted, that we had a completed claim form.

If, for example, a week ago he had submitted a claim for hypertension and the attached doctor bills and some drug bills and if he got one bill and he comes along and drops off a bill at the counter in the benefits area, we would accept that bill with the data claim form. It would be processed.

If we looked back in the file and there was no prior file within usually six months, as a rule of thumb that we use, then we would ask for a [60] completed claim form because the status of coordination of benefits, the diagnoses or whatever it might be, might have changed in the interim period.

Q. What if the worker sent in no information at all, would you normally hear from the hospital or from the doctor, or were you relying on the receipt of the form?

A. If we received a bill directly from the hospital, which is usually the way the bills come in from the hospitals, comes directly into the benefits area, we would then contact the employee informing them that we do have a bill and request that we be—send a claim out to him either through intercompany or through the U.S. mails to have him complete this form and return it.

Q. What if the worker just spoke with someone at the office and said, "Last month I had an operation and it was $90. When do I get my money back from the company?"

What would happen in that case?

A. The worker would be informed that he would have to—they would have to complete a claim form and present the appropriate bill or bills to them [61] for reimbursement. No payment is made without supporting medical evidence or itemization of the expenses.

Q. Why is that?

A. Well, I think I can use an analogy of us driving to work and our car breaks down. Because we're in front of a gas station, we leave it and go to work on a bus and come back that evening and the fellow says to us, "That will cost you $950." Are you going to ask what was done or are you just going to pay him $950.

You need proof of a claim and the expenses and the type of expenses and services that were rendered. Just need supporting evidence before any monies could be paid to anyone.

Q. When would you normally receive that proof?

A. Well, I think it can go to the extreme. I know of cases, because I have been up at Electric Boat, when an individual was released from Lawrence and Memorial Hospital in New London, had to pass by the benefits area going home and would stop off with a bill. They maybe had received the anesthesia bill or the surgeon's bill while they were still in the hospital and on the way home dropped it off for [62] payment. That would be an unusual situation but has happened.

The other extreme would be where someone would get a bill and just sit on it. But today, I am sure they would be receiving all kinds of dime notices to get the bill paid, and if you had benefits coverage, why you would not process a claim to get your benefits, I wouldn't know what the reason would be.

Q. Usually though the worker would send in the form and have the information with the form?

A. That's correct.

Q. And that is what you would rely on and act on?

A. That's correct.

MR. JOHNSON: That is all the questions I have.

MS. McNOWN: No redirect.

Off the record.

(WHEREUPON, discussion was had off the record.)

FURTHER DEPONENT SAITH NOT.

SCHAAL DEP. EX. NO. 1
FOR ID., AS OF 9/7/83

PRUDENTIAL
The Prudential Insurance Company
of America

Prudential's Group Insurance Claim Philosophy

(a) Our objective is to pay benefits promptly and accurately, when due.

(b) Although insurance may be purchased by groups, claims are presented by individuals and each claim is given the consideration we would expect to receive on our own claim.

(c) We pay no more and no less than provided by the contract.

Our claim practices are consistent with this philosophy:

1. Claims will be evaluated only by trained, capable people under experienced supervision.

2. Policy provisions will be applied uniformly in all paypoints, according to corporate group insurance memoranda.

3. Claims will be processed promptly. If any delay in settlement is anticipated, the claimant will be so notified.

4. Benefits are negotiated before the contract is issued, not when the claim is presented. Benefits are either payable or not payable; reasonable doubt will be resolved in favor of payment.

5. Any questionable claim will be thoroughly investigated and fully documented before a decision is made.

6. Claim decisions will be based on factual information only; only factual information will be recorded in our claim files; and all information will be held in confidence.

7. Claim decisions will not be influenced by the amount at risk.

8. Where circumstances indicate, professional medical and legal advice will be sought and respected.

9. A claim which is not payable, or on which benefits are being discontinued, will, before action is taken, be reviewed at a higher level than that of the person authorized to pay the benefit.

10. Whenever benefits are not payable, the claimant will be given a prompt, complete explanation and will be told of our willingness to review based upon any pertinent additional information.

Medical information seen by any claim personnel, no matter who or where they are, is a confidential communication:

11. Only those with a **need to know** are entitled to review such information.

12. Medical information passing between doctor, hospital and Prudential cannot be released without proper authorization. If a claimant asks for information regarding the diagnosis, he should be instructed to contact his personal doctor for it.

13. When you ask for further information from a doctor or hospital, be as specific as possible as to what you need and why (if the reason isn't obvious).

14. Some people are relatively relaxed about discussing their own illness; others prefer to be close-mouthed. Claims are to be processed as though everyone were of the latter type.

In the Supreme Court of the United States

No. 85-1385

UNITED STATES, PETITIONER

v.

GENERAL DYNAMICS CORP., ET AL.

ORDER ALLOWING CERTIORARI. Filed June 16, 1986.

The petition herein for a writ of certiorari to the United States Court of Appeals for the Federal Circuit is granted.

U.S. GOVERNMENT PRINTING OFFICE: 1986—491-507/20530